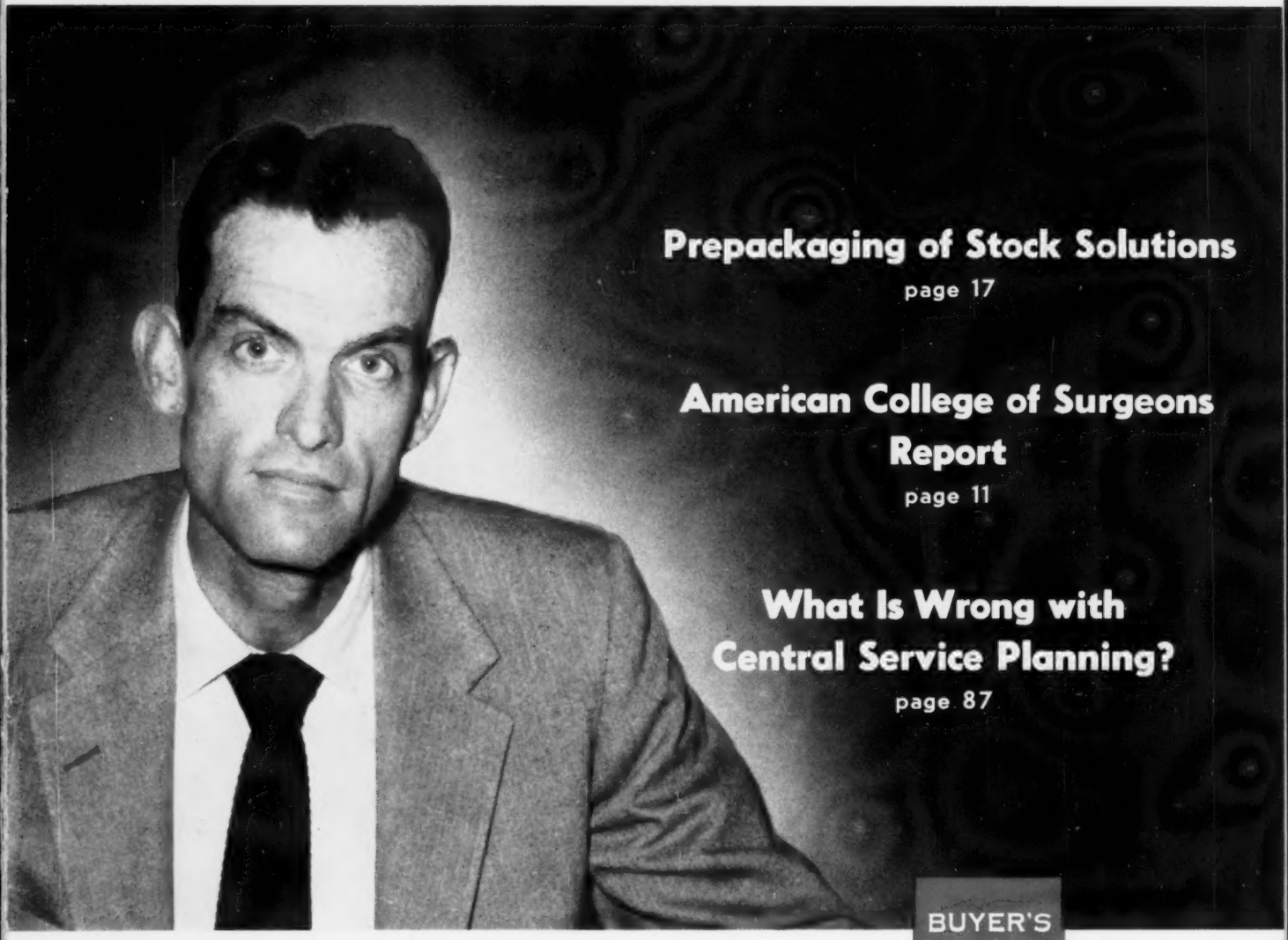
HOSPITAL Topics

THE NEWS MAGAZINE FOR HOSPITALS



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page 11

What Is Wrong with Central Service Planning?
page 87

BILL BURTON (see page 3)

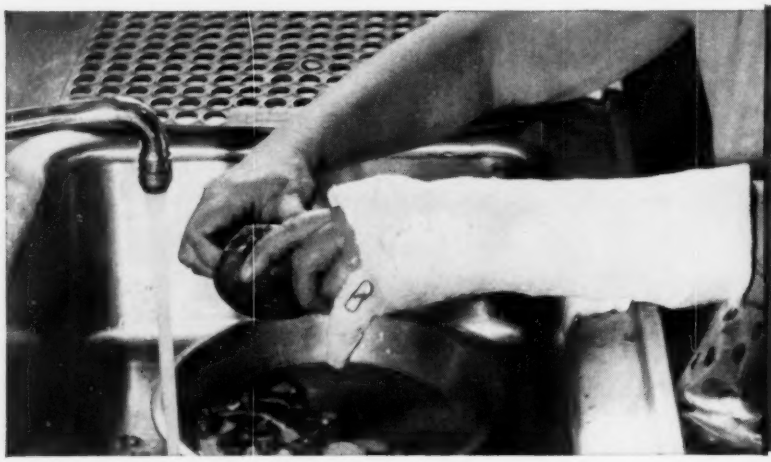
BUYER'S GUIDE
Page 50

DECEMBER | 1955

Now **MELMAC®**
resin plaster of Paris
BANDAGE

outmodes ordinary plaster

makes stronger, lighter, water-resistant casts



ready to use
combines resin, plaster of Paris and catalyst in one bandage. Just dip in water

▲

at last a water-resistant cast! Yet it's stronger than ordinary plaster! New casts of MELMAC® resin plaster of Paris BANDAGE can be washed—resist urine and wound exudate—are porous to water vapor. Are little affected by humidity or body moisture. Do not become soft, weak and soggy in humid weather as do ordinary plaster casts.

lighter, less fatiguing shoulder spica of MELMAC BANDAGE. Encourages prescribed exercise. Shortens hospital stay. Makes care easier. Bandage for bandage, MELMAC BANDAGE has 2 to 4 times the strength of ordinary plaster—is self-mending in the early molding stage. Fashion these better plastic casts with fewer bandages. ▶

Easy to apply and remove. 1. Just dip MELMAC BANDAGE into tepid water for 5 to 10 seconds. Squeeze out excess water thoroughly. Apply. 2. Use about half the usual number of rolls (or less). 3. Dispose of waste the same as with ordinary plaster. There is less mess. 4. Remove the thin cast easily with cast cutter, knife or cast saw. Send for sample.

Sensitivity: Since this product may contain traces of formaldehyde, persons who are known to be sensitive to it should be observed closely for dermatitis. Operators using the bandage repeatedly should wear rubber gloves if skin sensitivity exists.

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Sutures and other surgical specialties

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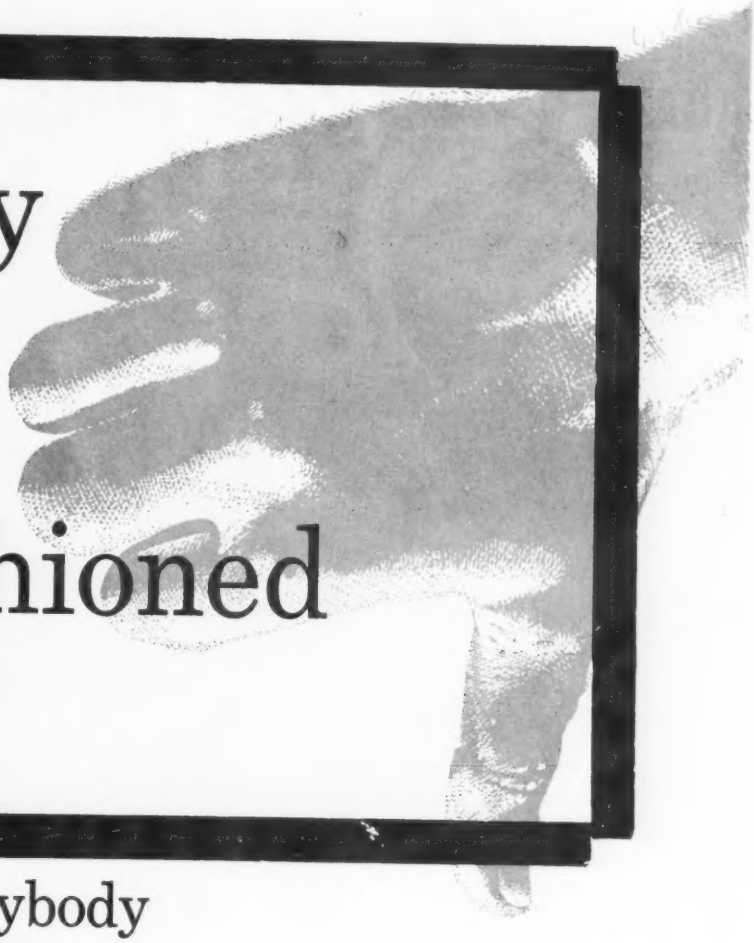
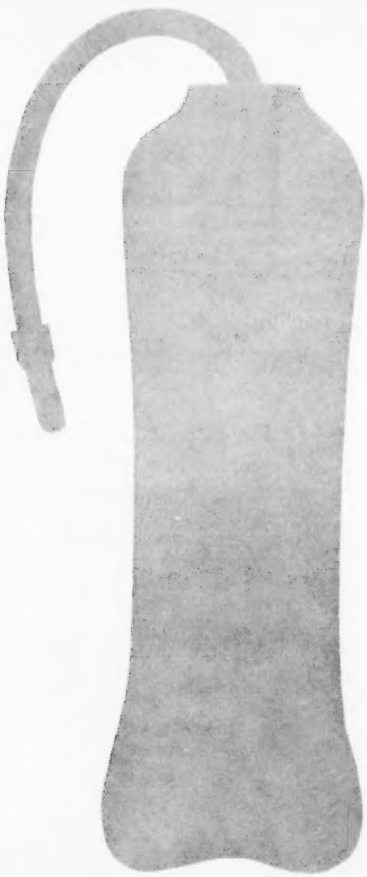
Nobody likes the old-fashioned enema





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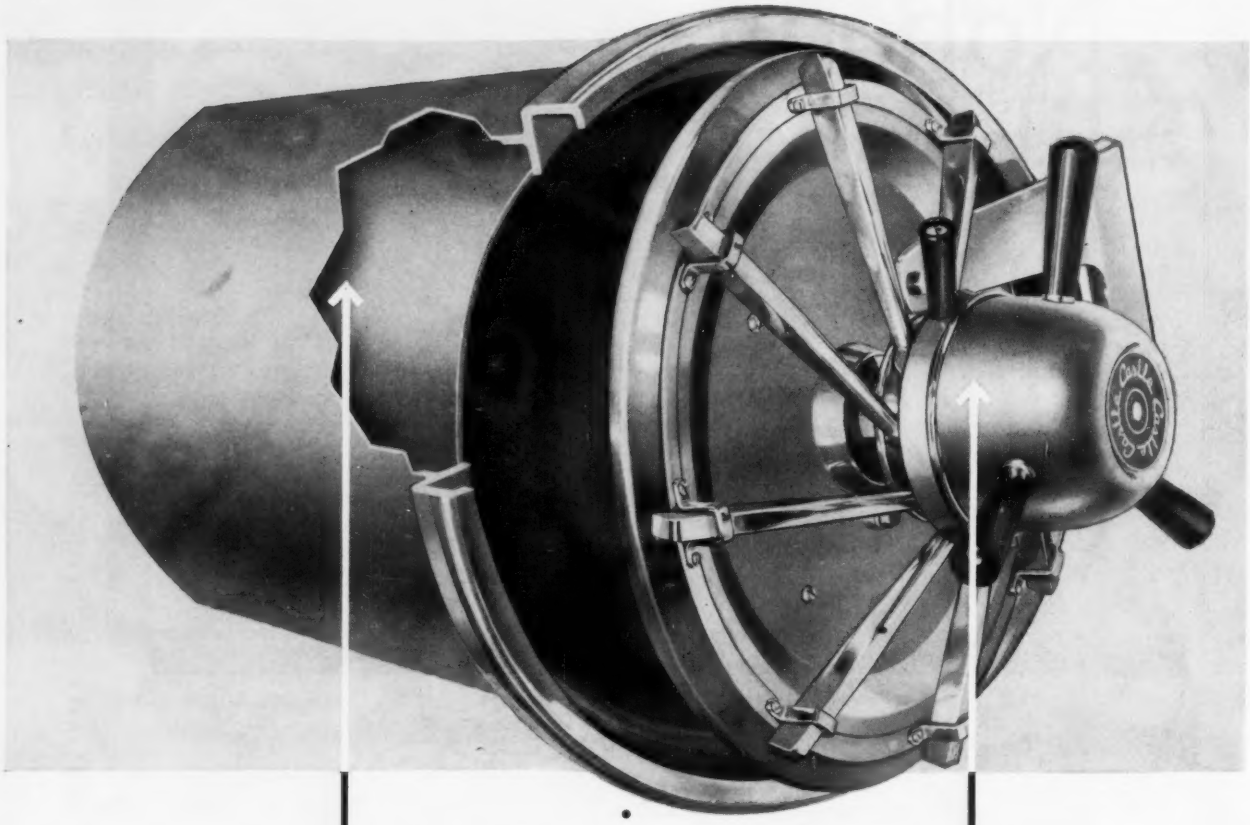

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HOSPITAL Topics
The News Magazine for the Hospital Staff
DECEMBER 1955, VOL. 33, NO. 12

G. M. Marshall
Publisher

J. F. Fleming, M.D.
Medical Editor

Marie Jett
Editor

Lois Smith
Managing Editor

Frances Henkin
Associate Editor

Nina Marie Stein
Editorial Assistant

Gunhild Moberg
Business Manager

Marcella Skandis
Advertising Production Manager

Virginia Page
Advertising Representative

Eileen McCaffery
Subscribers' Service

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PERSONALITY OF THE MONTH

Texans have a reputation for doing things in a big way and Bill Burton, administrator of Southwestern General Hospital, El Paso, is no exception. Since he entered the field of hospital administration in 1946 as a member of the business staff of Southwestern, Mr. Burton has joined and become an officer of almost every health organization in the El Paso vicinity.

To name just a few, he is past president of the El Paso and Southern New Mexico Hospital Council; past president, Northwest Texas Hospital Association; vice president, Texas Hospital Association; board member, El Paso County Chapter of the NFIP and the El Paso County Chapter, Texas Society for Crippled Children; chairman, 1953 March of Dimes in El Paso County. He is also a member of the American College of Hospital Administrators.

Mr. Burton, a native son of El Paso, graduated from Texas A & M College in 1939 and spent the next two years in Honduras working for the United Fruit Co. In 1941 he joined the Army. He was discharged as a lieutenant colonel in 1946 and began work in the business office of Southwestern General.

Mr. Burton is married and has five children—one girl and four boys. In his few leisure moments he enjoys woodworking and golf.

prescription pad

Perin Syrup Introduced For Pinworm, Roundworm

Perin syrup, a new product for the treatment of pinworm and roundworm infections, has been introduced by Endo Products, Inc.

Each 5 cc. contains the equivalent of 500 mg. piperazine hexahydrate. A palatable taste is provided by piperazine-calcium edathamil, a compound made in the Endo laboratories.

Suggested dosage for pinworms increases with body weight, and is given twice daily for 15 days. For roundworms, manufacturer says that one dose can eliminate worms and eggs.

Perin syrup is supplied in 4-oz., pint, and gallon bottles.

Mead Johnson Adds Two Vitamin Products

Deca-Vi-Sol, a new drop dosage dietary supplement for infants, and Natalins-PF, a phosphorous-free vitamin-mineral capsule for use in pregnancy, have been introduced by Mead Johnson & Co.

Deca-Vi-Sol, containing vitamins A, D, C, B_1, B_2, B_6, B_{12}, niacinamide, panthenol, and biotin, is suggested for protection against vitamin deficiencies.

Natalins-PF is intended to meet the needs of physicians who prefer a phosphorus-free vitamin-mineral capsule for use in pregnancy and lactation. Its balanced range of nutrients includes vitamins A, D, C, B_1, B_2, B_6, B_{12}, niacinamide, calcium pantothenate, folic acid, ferrous sulfate, and calcium carbonate.

Deca-Vi-Sol is being offered in 15 cc., 30 cc., and 50 cc. dropper bottles. Natalins-PF is packaged in bottles of 100 capsules.

Product Combines Zinc With Corticotropin

Cortrophin-Zinc, recently released by Organon, is an aqueous suspension of "purified" corticotropin with zinc hydroxide. Each cc. has 40 U.S.P. units of corticotropin with 2.0 mg. of zinc, and provides therapeutic ACTH activity for one to three days.

Since it provides both prolonged and enhanced ACTH activity, the manufacturer says that it may be given effectively in lower dosages and in fewer injections.

It is suggested for the treatment of shock, rheumatic afflictions, allergic reactions, skin and eye diseases, and other stressful conditions amenable to ACTH therapy, especially where natural stimulation of adrenocortical function is desired.

Cortrophin-Zinc is available in 5 cc. vials.

Provides Even Release Of Amphetamine

Synatan, the first commercially available tanphetamin protocolloid complex, provides for gradual and even release of amphetamine as its passes along the gastrointestinal tract.

A single dose is said to produce an extended uniform therapeutic effect which lasts throughout the day. When administered in the morning, Synatan produces a therapeutic response which continues for from 10 to 12 hours. The usual therapeutic dose is two tabules taken at 10 a.m.

Synatan, manufactured by the Irwin-Neisler Co., is available in bottles of 50 and 500.

Americaine Adds Neomycin

Neomycin has been added to Americaine topical anesthetic to provide an ointment to relieve pain and protect against infection at the same time.

The ointment contains 20 percent dissolved benzocaine plus 0.5 percent neomycin.

The manufacturer suggests application two to five times a day, with or without bandaging. Americaine ointment with neomycin is available from Arnar-Stone Laboratories.

New Anticoagulant Offered

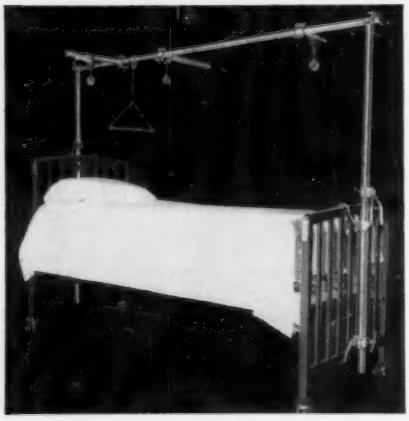
Dipaxin, a new anticoagulant drug released by the Upjohn Co., is a synthetic derivative of indandione.

It is available in 5 mg. scored tablets and is packaged in bottles of 100.

DePuy

NO-SLIP DESIGN
EASY-TO-USE
FITS ANY BED

new featherweight OVERHEAD FRAME



Nurses acclaim the new DePuy Featherweight Overhead Frame! Constructed of new octagonal *no-slip* aluminum alloy tubing for greatest strength with lightest possible weight . . . . only 28 lbs. So light, so easy to use that one nurse can set it up in a few moments. Easily adjusted with handy lever type clamps. *No-slip* design *stops* aggravating clamp slipping around tube. Will fit any type or size of bed, accommodating all types of traction apparatus. No. 654, complete with three abduction arms equipped with pulley and clamp, and trapeze assembly. Side Arm Traction Bars, and extra parts optional at added cost. Write now for more information and complete catalog of fracture equipment!

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clinical notes

Norepinephrine Increases Coronary Blood Flow

Norepinephrine increases coronary blood flow in myocardial infarction in much greater proportion than the rise in blood pressure, according to a group of investigators at Hahnemann Medical College and Hospital.

Jamison L. DeVera, G. Katakis, J. Alai, and H. T. Nichols write in the *Journal of the American Geriatrics Society* (3:521, 1955), that following administration of norepinephrine (Levophed), a rise in the oxygen content of coronary venous blood was observed. The blood was bright red, whereas after methoxamine it remained black. This furnished "direct evidence that the oxygen supply of the heart muscle is increased to a greater extent than oxygen utilization," according to the authors.

If a small dose does not produce a rise in blood pressure, a large dose will have the desired effect, they point out. In one experiment a dose of 0.5 mg. raised the blood pressure in a 36-pound dog from an initial 10 mm. Hg to 30 mm. Hg five minutes later, whereas doubling the dose to 1 mg. raised it to 100 mm. Hg in five minutes.

"Experimentally," they conclude, "Levophed is a potent coronary vasodilator and produces an increase in coronary blood flow far in excess of its effect in evelating the blood pressure."

IQ Increases Following Thorazine Treatment

Improved behavior was accompanied by a significant rise in IQ following the use of Thorazine in the treatment of 10 mentally retarded children exhibiting extreme behavior, Bair and Herold write in the October 1955 issue of the *Archives of Neurology and Psychiatry.*

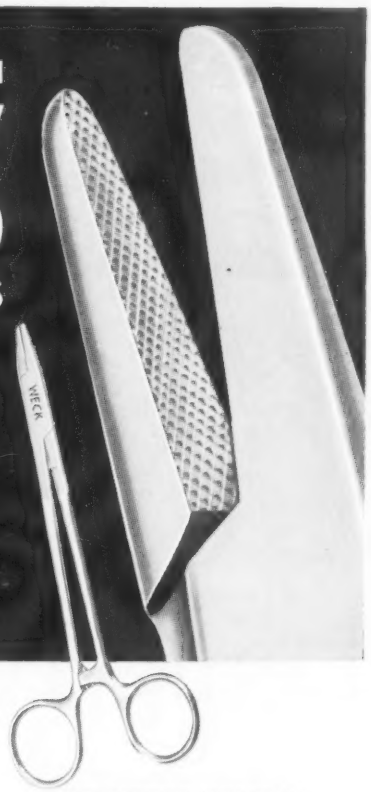
Bair, medical director, and Herold, psychologist, Parsons (Kans.) State Training School, attribute the rise in IQ to the "removal of severe emotional and nervous disorders which had prevented the students from functioning at their true level of mental ability."

The children selected to receive Thorazine were, in the opinion of the entire school staff, the most hyperactive students there. They were destructive and boisterous, and could not make even a minimal adjustment to institutional life. Following 60 days of Thorazine treatment, the mean IQ of the group had risen by an average of 10.4 points per student. Seven of the 10 were observed to have vastly improved behavior, and two improved favorably. Only one showed no significant improvement.

Particularly striking results were seen in one exceptionally pugnacious 15-year-old boy, whose IQ increased by 25 points. The authors note that he now "appears to have taken a new attitude toward life in general."

In a control group, the IQ range was 26 to 88, as compared with 30 to 108 for the experimental group. Upon retesting at the end of the 60-day period, an average IQ increase of 2.5 points per student was noted, as compared with the 10.4 points increase in the experimental group.

NEEDLE HOLDERS WITH
ALL-NEW IMPROVED
"BULLDOG"® JAWS
—another
WECK
achievement



In the new Weck Needle Holders the serrated areas of the jaws have been hardened by a special carburizing process forming complex carbides that provide just the right combination of hardness to resist wear, assure a firm grip and, at the same time, protect the needle from injury.

The serrations are an integral part of the jaws – not an insert – and are so patterned that the needle fits tightly into the grooves.

As illustrated, Weck Needle Holders with the new, improved "Bulldog" Jaws are identified by the new Weck "Glare-Proof" Finish on the jaw end.

The new, improved Weck "Bulldog" Jaws are now available in the Needle Holders listed at the right.

WECK NEEDLE HOLDERS WITH "BULLDOG" JAWS
— made of Stainless Steel

S15-520W	Collier 5"	$ 8.60 ea.
S15-570W	Baumgartner 5"	8.60 ea.
S15-566W	Hegar-Baumgartner Needle Holder 5½"	8.60 ea.
S15-548W	Crile-Murray 6"	8.60 ea.
S15-550W	Crile-Murray 7"	9.30 ea.
S15-540W	Crile-Wood 6¼" Light Pattern	8.60 ea.
S15-544W	Crile-Wood 6¼" Heavy Pattern	8.60 ea.
S15-552W	McAllister 6½"	12.00 ea.
S15-632W	New Orleans 7"	10.00 ea.
S15-590W	Mayo-Hegar Narrow Jaw 6"	8.60 ea.
S15-594W	Mayo-Hegar Narrow Jaw 7"	8.60 ea.
S15-598W	Mayo-Hegar Narrow Jaw 8"	10.00 ea.
S15-580W	Mayo-Hegar Broad Jaw 7"	9.30 ea.
S15-584W	Mayo-Hegar Broad Jaw 8"	10.00 ea.
S15-600W	Masson 10½"	10.70 ea.

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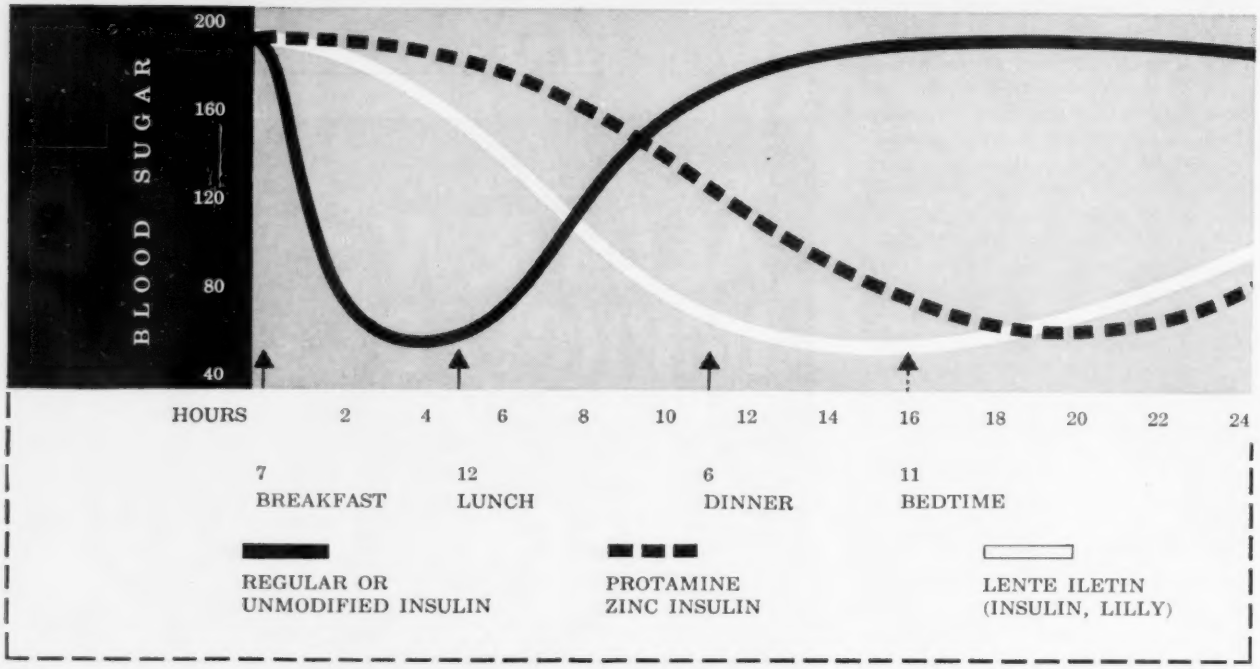
a preferred basic Insulin for all diabetics



Lente Iletin (Insulin, Lilly)

Another step toward the ideal Insulin

Simplified administration—Only one injection a day controls the majority of diabetic patients.

Simplified therapy—Approximately 85 percent of all diabetic patients can be treated with Lente Iletin (Insulin, Lilly) alone.

Simplified formula—Lente Iletin (Insulin, Lilly) is the only intermediate-acting Insulin free of foreign modifying proteins.

Simplified identification—The new distinctive "Hexanek" bottle makes identification easy.

Supplied in U-40 and U-80 strengths at all pharmacies.

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HOSPITAL Topics
The News Magazine for the Hospital Staff

December 1955
VOL. 33, NO. 12

Scanning the News

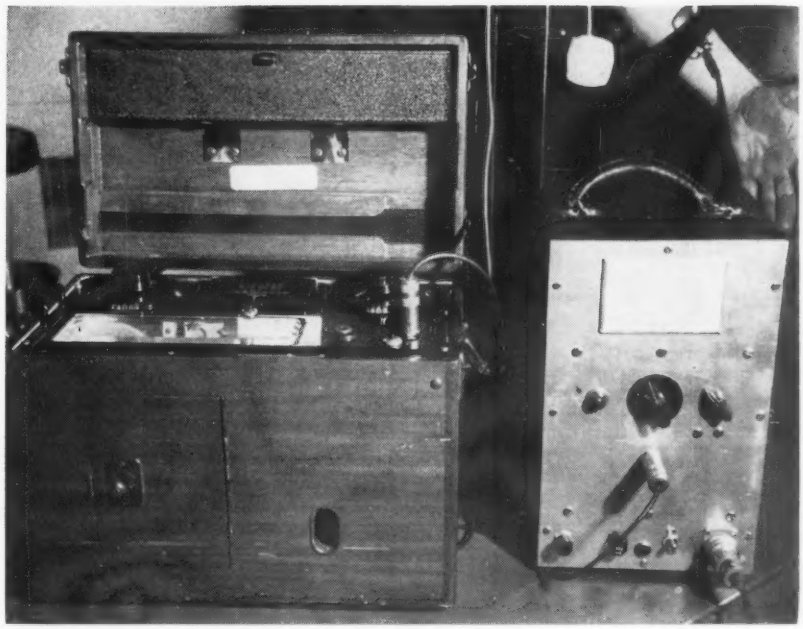
Trigger Synchronizes Heart X-Rays

With the new cardioroentgen actuator, a complex trigger for x-ray machines, the taking of x-rays at known times in the heart cycle no longer is a matter of guesswork.

Developed by the Public Health Service at the Laboratory of Technical Development, National Heart Institute, Bethesda, Md., the machine enables the physician to be certain the x-rays taken even years apart are taken at exactly the same instant in the heart cycle.

The photograph at the right illustrates the operation of the instrument. The actuator (right) operates in conjunction with an electrocardiograph (left) that traces the heart's electrical activity. The electrocardiograph signal triggers the x-ray exposure at any selected time in the heart cycle.

A monitoring photo cell, hanging below the patient's elbow in the background of the photograph, detects the x-ray exposure and feeds an electrical impulse back into the electrocardiograph curve, marking the exact time of exposure. A calibrated switch on the actuator allows for proper time selection.



Close-up of the cardioroentgen actuator shows the ECG unit (left) and the actuator (right) which triggers the x-ray apparatus. The calibrated switch on the actuator allows for proper time selection with respect to heart rate. The photo cell hanging near the patient's arm detects the x-ray exposure and feeds the pulse rate back into the ECG, marking the time of exposure. Story is at left.

Chemical Tells of Heart Muscle Damage

A test designed to show the extent of damage to heart muscles in coronary attacks has been made on 400 patients, it was reported recently at a meeting of the California Heart Association.

The test involves a chemical substance found in the blood stream after damage to heart muscle by blocking of a coronary artery. Some of the cells in the muscle, deprived of blood, die.

Then the system begins to clean up the dead cell area. Transaminase, the chemical, helps in the cleanup process. The amount of the chemical appearing in the blood is a measure of the amount of cleaning that has to be done, and also of the extent of damage.

Estrogen Controls Severe Bleeding

The female hormone estrogen may be the solution to profuse nose bleeds and severe hemorrhages following removal of adenoids, a New York physician has reported.

Estrogen, when given intravenously or intramuscularly, stopped bleeding within one hour in all but two cases. Those cases were controlled within three hours. No side effects were reported, according to Harold C. Menger, M.D., Evangelical Deaconess Hospital, Brooklyn, N.Y.

New Pump-Oxygenator Used at VA Hospital

An inexpensive pump-oxygenator has been used on more than 500 successful non-human heart surgery operations by the VA hospital, Nashville, Tenn.

Developed by Frank Gollan, M.D., of the hospital staff, the machine may be used for human surgery in the near future.

It by-passes the heart and lungs and maintains circulation of the blood after removing carbon dioxide and supplying new oxygen while heart and lungs are at rest. The heart is available for surgery, and with the lungs collapsed there is room for the surgeon to work.

In the use of the machine for surgery the body temperature is lowered by a refrigerated coil in the pump system, and hypothermia is produced.

The VA machine can be operated by only one individual while the surgeon operates on the heart. Dr. Gollan estimates it can be manufactured for less than $250.

(Continued on page 41)

Calendar of Meetings

DECEMBER

1- 2 Illinois Hospital Association
Springfield, Ill.

5- 8 American College Hospital Administrators 11th Fellows' Seminar, Evanston, Ill.

5- 9 AHA Institute for Medical Record Library Personnel, Dallas.

8-10 Texas Association of Blood Banks, Shamrock Hotel, Houston.

12-14 Missouri Hospital Association
Hotel Jefferson, St. Louis, Mo.

12-14 American Academy of Obstetrics-Gynecology, Conrad Hilton Hotel, Chicago

JANUARY 1956

28-Feb. 2 American Academy of Orthopedic Surgeons, Palmer House, Chicago.

30-Feb. 1 Association of Operating Room Nurses, Hotel Statler, Boston.

FEBRUARY

8- 9 National Association of Methodist Hospitals and Homes, Jefferson Hotel, St. Louis, Mo.

8-10 American Protestant Hospital Association, Hotel Jefferson, St. Louis, Mo.

11-14 Annual Congress on Medical Education and Licensure, Palmer House, Chicago.

MARCH

12-14 New Mexico Hospital Association, Hilton Hotel, Albuquerque, N. M.

14 Wisconsin Hospital Association, Milwaukee, Wis.

19-22 American Academy of General Practice, D. of C. National Guard Armory, Washington, D.C.

26-28 New England Hospital Assembly, Statler Hotel, Boston, Mass.

APRIL

3- 5 Kentucky Hospital Association, Hotel Phoenix, Lexington.

3- 5 Texas Hospital Association
Statler-Hilton Hotel, Dallas.

9-12 Ohio Hospital Association,
Deshler-Hilton Hotel, Columbus, O.

12-13 Carolinas-Virginias Hospital Conference, Hotel Roanoke, Roanoke, Va.

18-20 Southeastern Hospital Conference
Shelborne Hotel, Miami Beach, Fla.

21-27 Industrial Health Conference
Convention Hall, Philadelphia, Pa.

23-26 Association of Western Hospitals
Olympic Hotel, Seattle, Wash.

25-27 Mid-West Hospital Association
Municipal Auditorium, Kansas City, Mo.

26 Iowa Hospital Association, Hotel Savery, Des Moines, Ia.

30-May 3 Tri-State Hospital Assembly
Palmer House, Chicago.

MAY

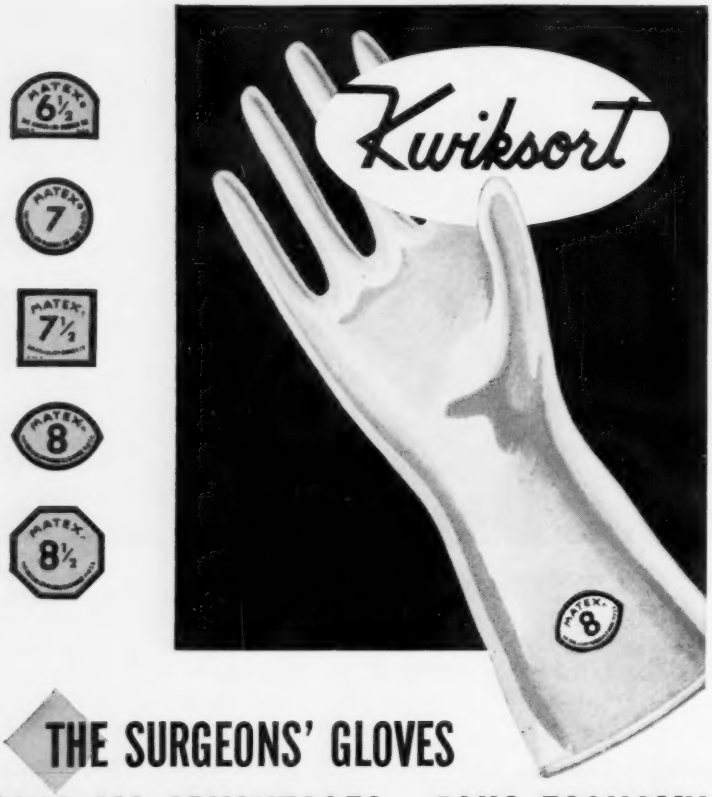
10 Annual Meeting, Massachusetts Hospital Association, Hotel Statler, Boston.

14-18 American Nurses Association
Conrad Hilton, Chicago.

16-18 Middle Atlantic Hospital Assembly
Convention Hall, Atlantic City, N.J.

21-24 Catholic Hospital Association
Municipal Auditorium, Milwaukee, Wis.

23-25 Upper Midwest Hospital Conference
Nicollet Hotel, Minneapolis, Minn.



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OFFERING ALL ADVANTAGES—PLUS ECONOMY

MATEX (white) and **MASSILLON Latex** (brown) surgeons' gloves are economical to use—regardless of original cost. This is true because:

♦ MATEX and MASSILLON Latex gloves are made from pure, virgin latex. Thus they resist the adverse effects of repeated autoclaving—and last longer.

♦ Exclusive KWIKSORT permanent and indestructible size markings speed sorting and pairing—reduce labor costs.

♦ And they are anatomically designed for perfect fit—to provide comfort and bare-fingered tactility.

For greater economy and satisfaction — get MATEX and MASSILLON Latex surgical gloves from your hospital supply source.

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MASSILLON RUBBER COMPANY
MASSILLON, OHIO

News Briefs at Press Time

State, Territorial Health Officers Make Recommendations on Issues

Principal recommendations made by Association of State and Territorial Health Officers, at annual meeting in November, include:

–Extension of cutoff date (now February 15, 1956) for federal grants to help states finance purchase of Salk polio vaccine.

–Extension of Hill-Burton Act through June 30, 1960.

–"Substantial increase" in number of improvised hospital units available for disaster use, and use of federal funds to help states defray costs of civil defense administration.

Organization pledged co-operation with Public Health Service in providing medical and hospital services for Indians.

Predict Reaffirmed Administration Stand on Key Health Issues

Administration is expected to reaffirm its stand in next Congress on key health proposals–including re-insurance. Prediction is that Congress will be offered a modified version of that plan.

Renewed recommendation for social security coverage of physicians and dentists seems pretty certain, Also, administration may yield to pressure to add disability insurance benefits to social security law.

Code Proposed to Govern Health Insurance Policies

Proposed code governing advertising of accident and health insurance is being distributed by National Association of Insurance Commissioners among its state members.

All advertising of health and accident insurance, indemnity- or service-type, is involved, as well as descriptive literature and oral representations made by brokers and agents. Code would ban misleading phrases and would insist that exceptions, restrictions, and limitations of policies must be made clear.

Gordon M. Marshall

Merry Christmas

from the staff of

Hospital Topics

Clockwise around the table—

Eileen McCaffery

Frances Henkin

Gordon M. Marshall

Gunhild Moberg

Sandra Levy (standing)

Virginia Page

Betty Miller

Mary Daley (standing)

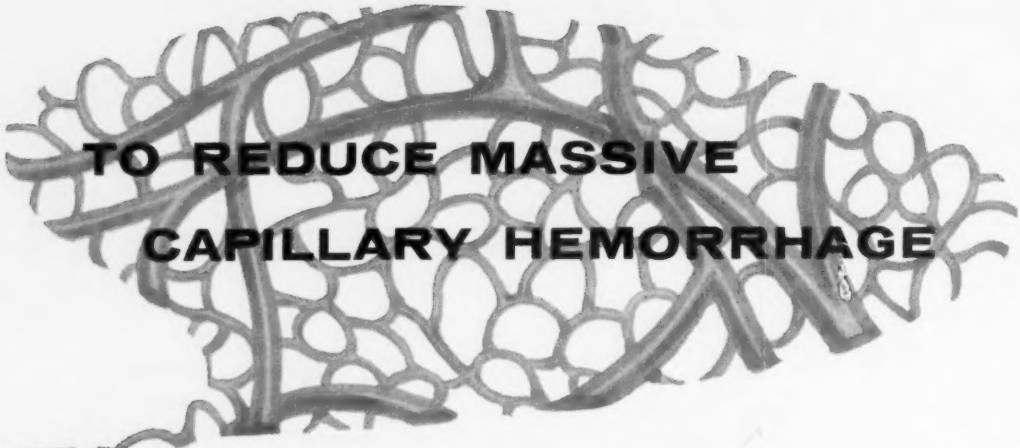
Marie Jett

Nina Stein (standing)

Lois Smith

Elsie Dorsch

Florence Freundt



TO REDUCE MASSIVE CAPILLARY HEMORRHAGE

Kutapressin®

Kutapressin—a highly selective vasoconstricting derivative from liver—acts with promptness on abnormally dilated terminal arterioles and capillaries—without increasing systemic blood pressure.

The rapidity with which Kutapressin constricts dilated vessels, decreases permeability, eases local congestion, suggests its wide range of usefulness in the hospital.

- Prevention and reduction of capillary bleeding encountered in tonsillectomies, adenoidectomies and other procedures
- In preparation of third degree burns for grafting
- Helps keep surgical field clean
- Plastic surgery
- Eye and brain surgery
- Reduces tissue trauma due to sponging

No systemic side reactions have been observed following its use.
It is free from protein material, is not antigenic, is well tolerated.
No untoward effects have ever been reported.

Kutapressin may be administered intramuscularly or subcutaneously.

Supplied: Aqueous Solution, 2 cc. ampuls; 10 cc., 20 cc. multiple-dose vials.

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41st Annual Clinical Congress

American College of Surgeons

● *Abstracts of some of the outstanding papers presented at the 41st annual clinical congress of the American College of Surgeons, held recently in Chicago, are presented here in HOSPITAL TOPICS' report. Additional material from the meeting will appear in the "O.R." section of the January issue.*

Tissue Committee Organization Difficult in Small Hospitals

Investigate Problems Locally; Give Information to Boards

Problems in hospital committee organization are more difficult in small hospitals than in large medical centers. Standards of accreditation formulated for large centers are difficult to apply to the small community hospital. Problems of meeting attendance, record-keeping, and patient complications should be investigated locally and the accumulated information passed on to members of the accrediting boards.

San Jose (Calif.) represents a growing community with a steadily increasing population and an influx of physicians, The trade area, of 12 mile radius, is served by two hospitals. In the last 10 years, population figures for this area alone have doubled while bed capacity has increased only 70 percent. Physician population (all types) has increased more than threefold in the same period. Today there are 591 beds available for 628 physicians.

Ninety-nine percent of the physicians are staff members of both hospitals. One-third of the staff also serve the local county hospital. General surgeons, general practitioners, obstetricians and gynecologists work together harmoniously. All members of the county medical society are eligible for membership on the hospital staff and serve an "apprenticeship" of one year under a sponsor who has already attained staff membership.

Each department is managed by a committee of at least five men representing all groups. The functions of the department committees range from management and liaison to supervising resident training programs, advising nursing staff, and providing consultation services for the hospital.

Duplication of staff membership makes compulsory meeting attendance a difficult accomplishment. This has been partially resolved by relegating monthly department meetings to one hospital and quarterly staff meetings to another. In each case, program material is arranged in rotation by each department.

The tissue committee includes a member of each department, the pathologist, and one general practitioner. The chairman is the representative of the surgical department. The committee considers a detailed study of all tissues submitted to the pathology department; all cases in which there is an inconsistency between diagnosis and pathological diagnosis; normal tissues removed, and deaths. If there are indications of improper practice, the physician involved is interviewed at this level. If further action is indicated, the case is referred to a senior governing committee.

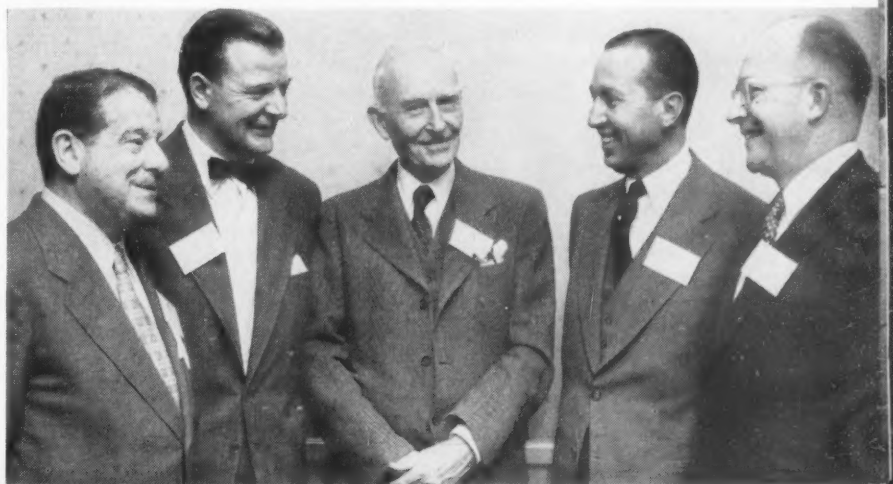
The percentage of normal tissues removed has dropped to 0.2 of one percent. Autopsy rates are increasing and rates of Caesarean sections have dropped to less than 5 percent. **Leon P. Fox, M.D.**, San Jose, Calif.

First Transplanted Kidney Continues to Function

Too Early to Tell Whether Outcome Is Permanent

The first kidney to be transplanted from a healthy identical twin to his brother, suffering from terminal glomerulonephritis, continues to function more than nine months after operation.

(continued on next page)



The International Co-operation Administration is co-operating with the ACS program to bring foreign surgeons to this country for postgraduate study. Shown here with their ACS hosts are two European surgeons who had just recently arrived to study under the program. L. to r.: I. S. Ravdin, M.D., Philadelphia, chairman, ACS board of regents; Polle Sonder, M.D., Copenhagen, Denmark; Allen O. Whipple, M.D., Princeton, N.J., director of ACS program in co-operation with International Co-operation Administration; Antonio Ferreira, M.D., Lisbon, Portugal; and John Hanlon, M.D., director, ICA part of program in Washington.

Clinical 2

The patient's general health improved rapidly. Fundoscopic examination returned to normal within five weeks. His blood pressure has fallen from hypertensive levels to a high normal level, and he has gained over 30 pounds in two months. His blood urea nitrogen has fallen from uremic to normal levels.

It is still too early to be certain that this kidney will function permanently or that it will not become involved with vascular or nephritic components of his underlying disease. However, to date this kidney has functioned in a perfectly normal manner as shown by clinical improvement, by divided functional tests, and by intravenous pyelograms.

The transplanted kidney does not rest in its natural place in the body, but in a position that permits the ureter to be better implanted into the bladder. The patient's own kidneys have since been removed because we felt they might ultimately interfere with function of the normal kidney.—**Joseph E. Murray, M.D., John P. Merrill, M.D., and J. Hartwell Harrison, M.D.,** Departments of Medicine and Surgery, Peter Bent Brigham Hospital, Harvard Medical School, Boston.

Surgery for Child's Ulcers Will Not Harm Growth

Rate Retarded Briefly; Then Gain Is Rapid

Partial removal of the stomach of a child suffering from peptic ulcers will not permanently interfere with the youngster's growth and development, an animal study has indicated.

The nutritional success and low ulcer recurrence rate reported in adults following hemigastrectomy, gastroduodenostomy and vagotomy suggested that this operation might be satisfactory for the child.

In our study, four litters, each containing four to six healthy puppies, were selected. At ages varying from two to four weeks, one-half of each litter was submitted to hemigastrectomy, gastroduodenostomy, and vagotomy. The remainder of each litter served as control animals. Growth and general development have been studied in these puppies for from six months to one year.

Results indicate that growth in the resected animals is retarded for a short time immediately after operation. Thereafter the rate of gain is rapid, and size and weight shortly equal those of the litter mate controls. The weight of the smallest animal operated upon is 15 percent below the average weight of litter mate controls. Several of the animals operated upon exceed the average weight of their controls. One animal operated upon is the largest of his litter.—**Jack A. Thompson, M.D., Joseph A. Bonta, M.D., H. William Clatworthy, M.D.,** Department of Surgery and Surgical Laboratories, Ohio State University Health Center, Columbus, O.

New Method for Closing Septal Defects Developed

Polyethylene Plate Inserted; Little Tissue Reaction

An experimental method for closing ventricular septal defects has been developed in experimental animals. A polyethylene plate is inserted into the defect and anchored by its own suspension sutures.

Seventeen out of 20 dogs survived the operation and recovered. Very little tissue reaction was noted.

We have noted a marked similarity of conditions under which we have repaired ventricular septal defects to those seen in human pathological specimens so far examined. This technic may, therefore, eventually have some usefulness for treatment of these defects in man.—**Judah Folkman, B.A.,** Children's Medical Center, Boston, and Harvard Medical School.

Carbon Dioxide Used with Oxygen To Prevent Fibrillation

Allows Lowering Temperature Further in Heart Surgery

By mixing carbon dioxide with oxygen, we have been able to prevent ventricular fibrillation in 10 consecutive animals undergoing open heart operations with hypothermia.

Ten adult dogs, cooled breathing oxygen alone, fibrillated around 20° C., but none of the animals fibrillated when cooled below 10° C. after five to 10 percent carbon dioxide was added to the oxygen.

We believe that introduction of the carbon dioxide maintains the proper acid-alkali balance, and that any shift in this balance may cause fibrillation.—**F. John Lewis, M.D., and Suad A. Niazi, M.D.,** Department of Surgery, University of Minnesota Medical School, Minneapolis.

Intravenous Prostigmin, Xylocaine Used to Prevent Fibrillation

Combination More Effective Than Either Method Alone

The combination of intravenous prostigmin in large doses and infiltration of the S-A node with xylocaine appeared to provide better protection against ventricular fibrillation during hypothermia than either method alone.

Four groups of animals were used for our experiments. In the first group, which received neither treatment, ventricular fibrillation occurred in approximately 90 percent of the animals when rectal temperature was lowered to between 24 and 26° C.

Fibrillation occurred less frequently in the group receiving prostigmin intravenously, and even less frequently in the third group, which was given an injection of 5 cc. of one percent of xylocaine. In the fourth group, which received the combined treatment, ventricular fibrillation occurred in only one animal.—**Charles A. Hufnagel, M.D.,** Department of Surgery, Georgetown University School of Medicine, Washington, D.C.

Cold Water Effective In Treating Burns

Reduces Swelling, Pain, Loss of Fluids

Prompt application of cold water to a burned area results in significant inhibition of both edema and abnormal capillary permeability to plasma proteins.

Results in experimental animals were best when cold water compresses were applied within 60 seconds after the injury. Water from the cold tap (about 10° C.) was as effective as ice water (4° C.), and it was found unnecessary to continue the compresses for more than 15 minutes for maximal effect. Extensive scald wounds treated by dipping the anesthetized animal promptly into a cold bath for 10 to 15 minutes resulted in a pronounced reduction in subsequent erythema and excoriation.

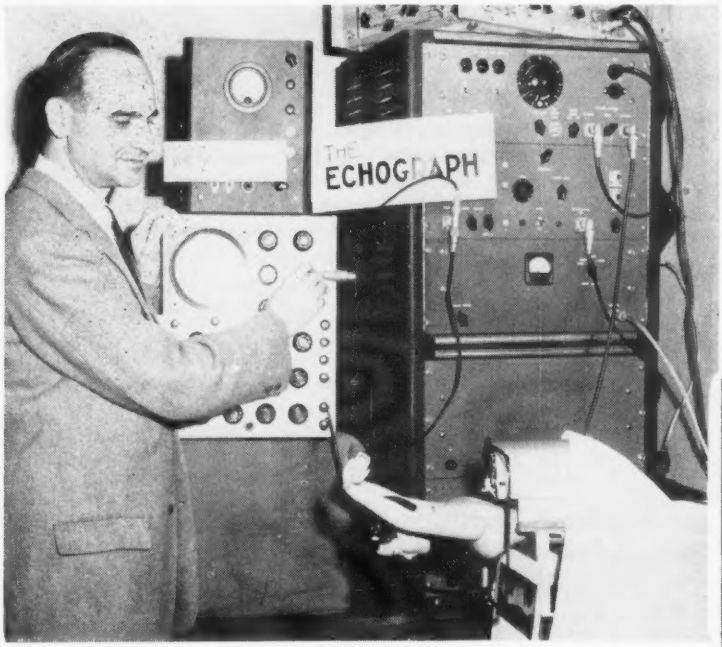
Human subjects reported significant relief of pain when

(Continued on page 14)

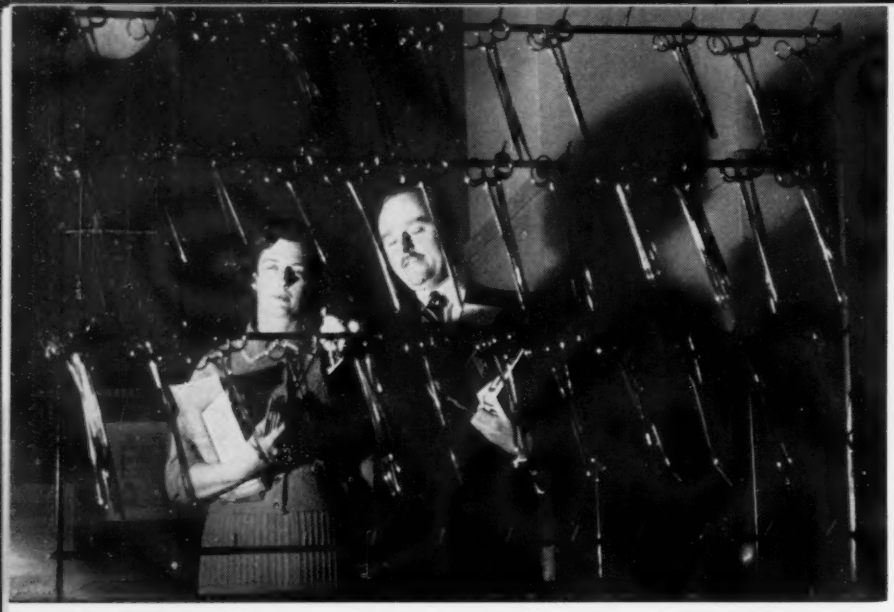
At left: Lt. J. W. Saville, M.C., U.S.N., Bethesda, Md., answers questions of Zigmund Kosicki, M.D., Chicago, and Mrs. Kosicki on the procurement, storage, and clinical use of tissue homografts. The exhibit emphasized the tissue bank development of freeze-drying of grafts.

Above: Jerome J. Landy, M.D., formerly at University of Chicago School of Medicine, and Gertrude Shorten at exhibit on surgical wound infections. More than 500 nose and throat cultures were taken of surgeons attending the congress. Results showing the proportion of potential pathogens and their antibiotic sensitivity will be announced.

Below: M. B. Rubinow, M.D., Manchester, Conn., examines Echograph mechanism suggested for mass scanning of breasts to detect cancer in very early stages. Exhibit, presented by John J. Wild, M.D., and John M. Reid, B.E.E., St. Barnabas Hospital, Minneapolis, Minn., showed that response of malignant tissue to mechanism, as revealed on charts, is quite different from response of normal tissue.



At right: W. Sterling Edwards, M.D., Medical College of Alabama, Birmingham, explains production and use of prefabricated nylon artery replacements to V. T. La Maida, M.D., Cleveland, and William D. Shorey, M.D., Chicago. Tubes of braided nylon of various sizes have been physically and chemically modified for use as arterial replacements. The soft, pliable, crimped tubes cannot kink on acute flexion and can be easily sutured to the host vessel, exhibitors say.



John R. Brown, M.D., Dayton, O., and Mrs. Brown stopped to examine attractive display of surgical instruments. They seemed particularly interested in forceps and diamond-jaw needle-holders.

cold was applied promptly to the injured areas.—**Levi E. Reynolds, M.D., C. Reed Brown, M.D., and Philip B. Price, M.D.,** Department of Surgery, University of Utah College of Medicine, Salt Lake City.

Tattoo of Blood Type Recommended for Defense

Sure Method for Having Information Available

Tattooing the blood type on every man, woman, and child in the United States is the surest method of having that necessary information available in case of widespread civil or wartime disasters.

It does no good to provide people with tags or cards, as these are frequently missing. The tattooing can be done at the waistline, an area usually protected by a belt, or in the lower armpit, another protected site.

Proper collection and storage of medical supplies are very important in preparation for disaster. In the confusion following the Worcester (Mass.) tornado two years ago, none of the 1,120 units of blood which were drawn locally in the first 24 hours could be used because of lack of refrigeration, lack of sterility, and lack of materials for proper typing.—**Frank B. Berry, M.D.,** Assistant Secretary of Defense (Health and Medical), Washington, D.C.

Cobalt Proves Effective For Sterilizing Cartilage

Method Simplifies Storage

Cartilage can be sterilized effectively and safely by cobalt 60 source and stored at room temperature in a sealed container in 0.9 percent sodium chloride without affecting its fate as homografted material, we have concluded as the result of an experiment with canine costal cartilages. This is a simple, inexpensive, positive method of sterilization and greatly simplifies storage and transportation problems.

Canine costal cartilages were used as homografts after sterilization by intensive irradiation (two to three million r.e.p.) from a cobalt 60 source. As a control, costal cartilage homografts sterilized and stored by the usual method in 1/4000 merthiolate solution were used.

The irradiated cartilage homografts were divided into three groups: (1) cartilage lyophilized, irradiated, and stored in vacuum sealed tubes at room temperature; (2) costal cartilage sealed in tubes containing normal saline, irradiated and stored at room temperature, and (3) cartilage sealed at atmospheric pressure, irradiated, and stored at room temperature.

Measured irradiated cartilage homografts from these three groups were placed subcutaneously over the calvarium and subfascially beneath the rectus sheath of nine dogs. Their sterility was studied by bacteriological methods and their fate studied at intervals by measurement and microscopic section of the cartilage.—**John D. Lynch, M.D., Richard B. Asbury, M.D., and Reed O. Dingman, M.D.,** Department of Surgery, University of Michigan Medical School, Ann Arbor.

New Technic Developed For Reconstructing Ureter

Uses Reversed Seromuscular Graft

A new concept for surgical reconstructive procedures involving the use of a reversed seromuscular graft has been investigated and applied to the problem of replacing or reconstructing the ureter. An isolated intestinal segment is opened along the mesenteric border, stripped of the mucous membrane, and reversed so that the serosa faces inward. Thus a clean, smooth, sterile graft material is provided.

This technic has been used in six dogs to replace the ureter from the kidney pelvis to the bladder. Results indicate that this procedure is promising enough to be applicable clinically.—**William C. Shoemaker, M.D., and Robert Bower, M.D.,** Departments of Surgery and Urology, Hahnemann Medical College and Hospital of Philadelphia.

Brain Perfusion Utilized In Open Heart Surgery

Has Advantages Over Other Methods for By-Pass

A "cross circulation" technic involving only the brain may help us to overcome some of the disadvantages of total body cross-circulation in open cardiac surgery.

We joined the proximal carotid artery of a donor dog to the distal carotid artery of a recipient. Blood was returned to the donor by joining the recipient's distal jugular vein to the donor's proximal jugular vein. The blood supply to the rest of the body was then cut off.

Of 44 dogs in which brain perfusion was used, 22 survived, and 16 remained in good health.—**William H. Peniston, M.D., and Victor Richards, M.D.,** Stanford University Hospital, San Francisco.

Hematoporphyrin Used in Visualizing Gall Bladder, Common Bile Duct

Glows Under Ultra-Violet Ray

Administration of hematoporphyrin may help surgeons to visualize the gall bladder and common bile duct.

Given intravenously to six patients, the substance was found to accumulate in the gall bladder and duct. It glows red under ultra-violet ray.

In acute cholecystitis, fluorescence of both gall bladder and common duct was observed, including an accessory biliary duct between the liver and the body of the gall bladder. In one case of chronic cholecystitis, the gall bladder was fluorescent, the common duct not so. In one patient with duodenal ulcer, a trace of fluorescence was noted in the gall bladder only.—**D. S. Rasmussen-Taxdal, M.D., Richard E. Ahlquist, Jr., M.D., and Chester E. Herrod, M.D.,** University of California School of Medicine and Stanford University School of Medicine, San Francisco, and **George C. Peck, M.D., H. Patterson Mack, M.D., William A. Holbrook, M.D., and Frank H. J. Figge, Ph.D.,** University of Maryland School of Medicine, Baltimore.

Undetected Kidney Damage May Cause Death in Surgery

Function Tests May Not Reveal Injury

Slight, undetected kidney damage—not revealed in kidney function tests—may cause death from stress of major surgery in an otherwise healthy animal.

Kidney damage was inflicted in experimental dogs by blocking key arteries or injecting toxic drugs into the kidney circulation. The animals then were tested with the blood urea nitrogen test and found to be on a par with a group of control animals.

Nine or 10 days later, all the animals underwent extensive operations, including removal of the spleen, gall bladder, and one kidney. The death rate in the experimental group was 38 to 53 percent; in the control group, only 7.1 percent.—**Emile L. Meine, Jr., M.D.,** Department of Surgery, University of Illinois College of Medicine, Chicago.

Intracranial Aneurysm Treated By Carotid Ligation

Effective in Preventing Recurrence

In one hundred patients with subarachnoid hemorrhage who have been treated by carotid ligation, 65 are alive and 25 dead, and the follow-up on 10 others is incomplete.

This treatment is effective in preventing further hemorrhages, and mortality is low.

Use of more radical surgery to treat intracranial bleeding due to aneurysms is accompanied by a forbidding mortality and morbidity.—**Nicholas Wetzel, M.D., and Richard Davis, M.D.,** Department of Surgery, Northwestern University Medical School, Chicago.

Cobalt Used to Sterilize Bone Transplants

No Immediate Harmful Effects From Irradiated Transplants

Relatively high levels of gamma radiation from a 10,000 curie radioactive cobalt source will render bone bacteriologically sterile, without changing the character of the bone or decreasing its ability to stimulate new growth.

The bone can be transplanted into dogs without immediate harmful effects.

Radiation will not preserve the bone, however. Irradiated bone, stored at room temperature for six months, showed a loss of bone marrow. There is need for a further method of preservation, such as freezing or free-drying.—**Paul H. DeVries, M.D.,** Department of Surgery, and **Lloyd Kempe, Ph.D.,** Department of Bacteriology, University of Michigan Medical School, Ann Arbor.

Technic Proves Effective For Cancer of Bladder

Uses Radium Source or Radioactive Cobalt

Irradiation of carcinoma of the bladder has resulted in a five-year survival rate of 56 percent in 50 patients treated with a technic devised during the war years at Walter Reed General Hospital. The technic entails placing a small radium source or radioactive cobalt pellet in the center of an inflated Foley catheter placed in the bladder. Although the technic is simple in principle, execution is complicated.

The unduly high five-year arrest rate is due to unusually favorable results from the first group of 13 patients. The eventual arrest rate will be lower, but still significantly higher than results achieved by modern surgical technics.—**Milton Friedman, M.D.,** Department of Radiology, New York University-Bellevue Medical Center, Post-Graduate Medical School, New York.

Cortisone May Help Lengthen Lives of Breast Cancer Victims

Improvement in 50 Percent Of Patients Treated

Cortisone, used in combination with thyroid therapy, may increase survival time in advanced breast cancer.

Significant improvement has resulted in about half of 30 patients treated. In several patients, the improvement has lasted more than a year.

Ovarian function must be wholly absent, either as a result of oophorectomy or age in excess of 65 to 70.

The combined treatment aids in suppressing the production of female sex hormones in pituitary-adrenal cortex secretions. The maintenance dose of cortisone must be at least 75 but not more than 100 mg. daily, because at above 100 mg. conversion to androgens and estrogens is possible. Thyroid is given in 60 to 90 mgm. daily doses.

This treatment has been effective as the initial form of therapy, obviating the need of extensive roentgen therapy, and also as a last resort, after extensive hormone therapy and radiation.—**Henry M. Lemon, M.D.,** Boston University School of Medicine.

Adding Artificial Dead Space Results in More Tidal Volume

Effective Against Atelectasis

Addition of an artificial dead space, through which a subject breathes, raises the CO_2 content of inspired air and results in an increased respiratory tidal volume without an appreciable increment in rate of respiration. This affords an effective and economical method of intermittently producing hyperventilation to prevent atelectasis.

Twenty laboratory subjects, breathing through a rubber tube with a volume of 1,000 cc., at the end of three to

(continued on next page)

Three presidents get together (l. to r.): Sir Harry Platt, president, Royal College of Surgeons, Manchester, England; Alfred Blalock, M.D., Baltimore, outgoing ACS president; and Robert M. Janes, M.D., Toronto, Ont., president, Royal College of Surgeons of Canada.

five minutes increased the tidal ventilation by approximately 100 to 200 percent of the control values. Equilibration occurred during the third to fifth minutes and persisted for the remainder of the ten-minute test, resulting in maintenance of the increase in tidal ventilation.

Fourteen patients have been studied preoperatively and during the first three postoperative days. Breathing through a tube which added 1,000 cc. dead space increased the tidal ventilation by 100 percent to 200 percent of the control values each day.

The 1,000 cc. dead-space tube is currently being evaluated for routine use on the wards to replace paper bag or five percent CO_2 rebreathing.—**Seymour I. Schwartz, M.D., and W. Andrew Dale, M.D.,** Department of Surgery, University of Rochester School of Medicine and Dentistry, Rochester, N.Y.

Hyperventilation Effective In Severe Chest Injuries

Applied by Mechanical Respirator

Hyperventilation by mechanical respirator has been applied by us to patients with severe crushing injuries of the chest. Seemingly hopeless cases have recovered following hyperventilation treatment. The most striking benefits include prevention of all paradoxical motion without external traction; correction of hypoxia and hypercarbia; absence of pulmonary edema; no deleterious changes in blood chemistry; mild semiconsciousness requiring less sedation, and no ill effects after as long as 30 days of hyperventilation treatment.

The well-known "hyperventilation syndrome" shows apnea, tetany, convulsions, unconsciousness and sometimes death. This is, however, true only in active hyperventilation, either in volunteers or in metabolic acidosis.

In passive hyperventilation the results are essentially different. The CO_2 is diminished, apnea occurs, but not hypoxia. Dogs were hyperventilated from one to six hours to produce severe respiratory alkalosis. The acid-base relationships of the blood were studied. When hyperventilation was ceased, respiration and all blood studies soon returned to normal. No late ill effects were seen. In patients a similar although much milder alkalosis has been produced, during surgical procedures for several hours, and in patients with bulbar poliomyelitis for as long as seven months. No ill effects were seen. Thus, we have good reasons to postulate that passive hyperventilation is safe.—**E. T. Mörch, M.D., Edward E. Avery, M.D., and D. W. Benson, M.D.,** Department of Surgery, Northwestern University Medical School, and Department of Anesthesia, University of Chicago Clinics, Chicago.

Emergency Patient on Stretcher Throughout Hospital Stay

Survey Showed Patients Moved Ten Times With Old Method

Injured patients at Hurley Hospital go from the emergency room, through all necessary departments, and finally to their beds without being moved from the original stretcher they were placed on. The specially constructed stretcher features legs that swing out so that the entire unit may slide over an x-ray table or operating table. The top is a tray-like arrangement which can be lifted from the base of the stretcher without disturbing the patient.

A survey conducted at our hospital in 1950 showed that the average accident patient brought into the emergency room was on and off the stretcher 10 times before he finally reached his bed. He was handled by the least experienced labor in the hospital, and injuries were often further complicated. There was danger to the patient, confusion, delayed diagnosis, loss of critical time, and waste of money.

New president is Warren H. Cole, M.D., professor and head, department of surgery, University of Illinois College of Medicine, Chicago.

The new system provides for proper transportation, earlier diagnosis, less confusion, and conservation of key personnel, time, and money. Moreover, the hospital is much better equipped to handle emergencies during a civilian disaster. The entire emergency procedure is much better integrated with the rest of the hospital. Also, the removable tops of the stretchers can be used as temporary beds in hallways if necessary.—**David R. Limbach, M.D.,** Chairman, Department of Radiology, Hurley Hospital, Flint, Mich.

Ambulance Injuries Reduced By Licensing Attendants

Patient Chart Has Record of Quality of Transportation

Further injury to accident victims due to poor transportation has been cut down considerably since a special city ordinance was passed to license ambulance attendants.

Each receiving room has a special chart for each patient admitted. Among the information included on this chart is a review of the quality of transportation and the attendant's name. No attendant is allowed more than three errors in proper handling.

At specific intervals, the ambulance attendants meet to hear lectures delivered by the resident staff on the proper methods of moving the sick and injured.—**George J. Curry, M.D.,** Chairman, Section for Surgery of Trauma, Hurley Hospital, Flint, Mich.

Prepackaging of Stock Solutions Saves Nursing Time, Speeds Service

By Louis Gdalman
Director of Pharmacy
St. Luke's Hospital, Chicago

Second in a series

Prepackaging in the pharmacy of the most commonly used stock solutions has helped speed up our delivery system and has resulted in a significant saving of nurses' time.

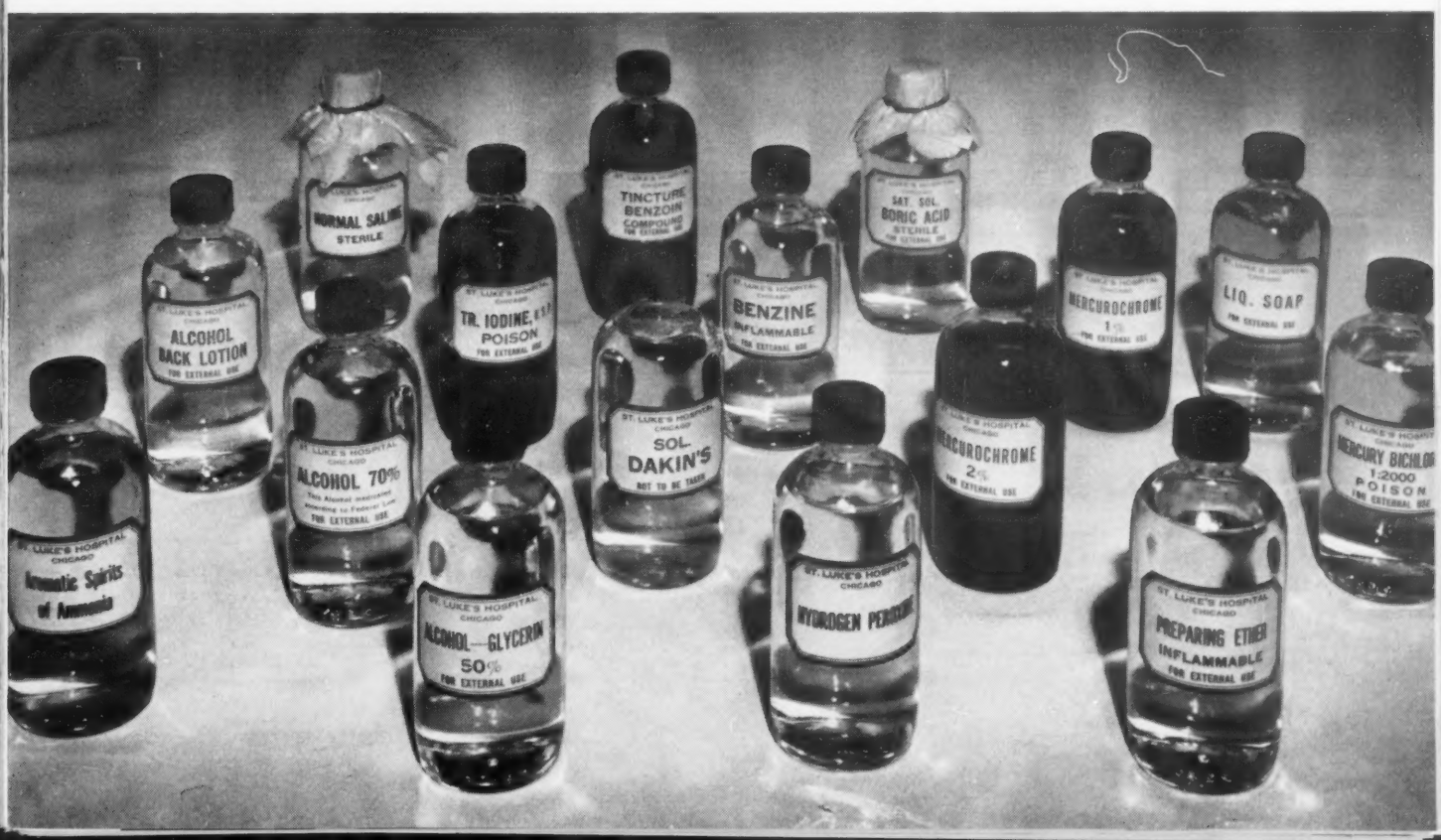
The small, prepackaged, labeled units are supplied by the pharmacy and kept on dressing carts on each of the hospital's 16 patient floors. A reserve supply is also maintained on each unit.

Nurses do not have to write out orders for replacements. Every empty bottle, returned to pharmacy, is an automatic re-order, and is replaced when departmental and stock floor orders are filled in the morning.

Before the system was introduced, there was no standardization of these bottles and their labels. The units on the dressing carts were filled and labeled by the nurses from larger containers supplied by the pharmacy. We had a conglomeration of sizes and shapes—unattractive as

(Continued on page 19)

Below: Samples of prepackaged units of stock solutions. Both bottles and labels are uniform in size. Return of empty bottle to pharmacy constitutes a re-order. Before present system was adopted, many different sizes and shapes were used, and nurses filled bottles on floors.



Above: IV fluid flasks are tagged at the neck with a heavy paper card which can easily be taken off the bottle. Rona Sturt holds bottle which has been tagged for delivery. On the card is a partially attached gummed label, the bottom part of which is to be filled in with date, room number, name of patient, and name of doctor when an IV flask is used. Completed fluid tags are returned to pharmacy, and bottles are replaced. In pharmacy, gummed labels (which fit addressograph) are torn off cards and pasted in right-hand corner of a standard pharmacy requisition and account ticket, priced, and sent to business office.

FORMALIN
Caustic — Poison
Add 5 drops to each routine urine specimen and to each specimen for Addis Count.
DO NOT ADD Formalin to specimens for culture or to 24 hour specimens.

Above: Plastic dropper bottle (actual size) designed at St. Luke's for holding formaldehyde for use in preserving urine specimens. Bottle was designed as a safety measure, since aides on floors also handle these bottles.

Below: Pharmacy requisition and account ticket (actual size), showing gummed label from IV flask pasted in corner. Necessary information is filled in on floors before flask is returned to pharmacy.

6 PHARMACY REQUISITION AND ACCOUNT TICKET

DISTRIBUTION: WHEN FORM IS COMPLETED SEND TO PHARMACY

INTRAVENOUS FLUIDS

5% DEXTROSE IN WATER 1000cc

DRUGS ORDERED

DESCRIPTION	DOSAGE	QUANTITY

IMPRINT INFORMATION REQUESTED BELOW AND SEND TO PHARMACY

Date _____ Room No. _____

Patient _____

Doctor _____

FORM 75-040

SIGNATURE OF HEAD NURSE

FORM 55-317 REV. 3-55

PRICED BY

$ _____ TOTAL CHARGE

well as impractical for the most efficient operation.

We decided on a 180 cc. or 6-ounce bottle with bakelite cap for the standard items. The following 18 items are prepackaged in these bottles:

Sterile distilled water
Mercury bichloride 1:2000
Sol. Dakin's
Sat. Sol. boric acid (sterile)
Liquid soap
Aromatic spirits of ammonia
Tincture benzoin compound
Alcohol-glycerin 50%
Alcohol 70%
Normal saline (sterile)
Alcohol back lotion
Preparing ether
Mercurochrome 1%
Mercurochrome 2%
Tr. iodine
Zephiran 1:1000
Hydrogen peroxide
Benzine

On each of the 16 floors we needed a minimum of 30 bottles. That meant that when the system was inaugurated we had to have about 500 bottles for the first distribution and another 500 for the first replacement.

In order not to interfere with the routine in our department or to inconvenience any of the floors, we worked one Sunday to put up the 1,000 bottles. We took the former stock solutions off the floors and replaced them with the prepackaged items. On Monday morning the hospital was working on the new system.

Unnecessary bookkeeping is eliminated. All the nurse has to do is place the empty bottle in the basket to return to pharmacy.

The pharmacy supplies about 150 stock floor items, including the above solutions, to each floor. These are service items, and the patient is not charged for their use. On all such stock floor drugs, interdepartmental charges are not made by individual items. Instead, each nursing unit is charged on a per diem cost, as determined by repeated inventories. We found that the average per diem figure corresponded to the cost obtained by totaling individual charges. Hence the need for a lengthy accounting system is eliminated and considerable time saved in the nursing, pharmacy, and accounting departments.

BOTTLE FOR HOLDING FORMALDEHYDE

Another container in use at St. Luke's was devised as a safety measure. It is a plastic dropper bottle for holding formaldehyde, which is used for preserving urine specimens. Formerly thymol was used for this purpose, but it interfered with the laboratory test. Formaldehyde proved effective, but also was a potential hazard. Since aides on the floors also handled the bottles, we wanted to take every possible precaution.

When this bottle (see illustration) is inverted, it drops just about five drops—the amount needed per specimen.

IV FLUID DISTRIBUTION

In addition to supplying the floors with prepackaged units of stock cart solutions, we also keep them stocked with the most often used IV fluids. We have about 38 different kinds and sizes of IV fluids in stock, but about 13 of them are the most used. We put an inventory stock of these solutions and also a stock of administration sets on each floor and in the operating room. These include:

5% dextrose in water, 1,000 cc. and 500 cc.
5% dextrose in salt, 1,000 cc. and 500 cc.
10% dextrose in water, 1,000 cc.
10% dextrose in salt, 1,000 cc.
Physiologic saline solution, 250 cc., 500 cc., and 1,000 cc.
Balanced electrolyte solution (Polysal), 1,000 cc.
Amigen 5%, 1,000 cc.
Levugen 10% in water, 1,000 cc.
Levugen 10% in electrolytes No. 45, 1,000 cc.
Administration sets:
  Direct (intravenous)
  Indirect (subcutaneous)
  Blood plasma sets

All are complete with needles and are disposable.

Fluid flasks are tagged at the neck with a heavy paper card which can easily be taken off the bottle. On this card is a partially attached gummed label (see illustration), the bottom part of which is designed to be filled in (fits addressograph) with the date, room number, name of patient, and name of doctor when an IV flask is used.

The fluids and sets are delivered to floors by a fluid delivery man, who begins rounds with his cart at about 7 a.m. He picks up the completed fluid tags and replaces the corresponding IV flasks and administration sets. In the pharmacy the gummed labels are torn off the cards and pasted in the right-hand corner of a standard pharmacy requisition and account ticket, priced, and sent to the business office.

This system takes care of 95 percent of all fluid orders; maintains a readily available stock for immediate use at all times on each nursing unit; eliminates the need for the nurse to order fluids for individual patients; eliminates credits on over-ordering; prevents overcharging, and, most important, saves considerable nursing time.

"Now, on the morning of the 10th my temperature went down two degrees and I felt pretty good. Then . . . "

American Dietetic Association Holds Annual Convention in St. Louis

Stress Short-Term Effects of Diet On Blood Coagulation Process

Fat Shortens Clotting Process

Intravascular clotting can be accelerated by eating small amounts of fat in the form of cream, olive oil, refined corn oil, or butter. A 40 percent shortening of the normal clotting process is effected, with results detectable within one-half hour after eating and reaching a maximum in one hour.

This phenomenon is important where single foods are fed and is one of the reasons for the effectiveness of the milk and cream diet in gastrointestinal bleeding. Prolonging the diet beyond the necessary control period carries the hazard of intravascular thrombosis, since these lipids also slow circulation in the fine capillaries. Fortunately the clot-accelerating effect may be mitigated by the simultaneous feeding of sugar. Sugar-modified milk and cream formulas should be introduced as soon as gastrointestinal bleeding has stopped.—**Jerome M. Waldron, M.D.,** Associate Professor of Physiology, Temple University Medical School, Philadelphia.

Study Finds Food Losses Higher In Large Institutions

Nutrient Loss Also Higher

A two-week study on food issued and discarded was made at four institutions—two old-age homes and two children's homes. Population in three of the institutions was from 90 to 804 persons. In one children's home, food was prepared in individual cottages with 15 residents each.

Food losses in the large institutions were about one-fifth to one-fourth of the total food issued. The loss was only five percent in the small institution. Food groups showing the greatest loss in proportion to issue included leafy, green and yellow vegetables, potatoes, meat, dry beans, and peas. Milk, cream, ice cream, cheese, citrus fruit, and tomatoes showed the least proportionate loss.

Iron and niacin were the nutrients showing the highest losses. The nutritive values of food lost in the children's institutions were higher than those in the old-age institutions.—**Constance L. Brine, Ph.D.,** Consultant in Institutional Dietetics, Arthur D. Little, Inc., Cambridge, Mass., and **Edith B. Tate,** Food Economist, Agricultural Research Service, U. S. Dept. of Agriculture, Washington, D.C.

Consider Future Needs In Planning Kitchens

Makes Later Expansion Economical, Efficient

Three things should be done in the original construction of a kitchen planned to grow into increasing production: (1) The floor space required for maximum production should be built; (2) service lines should be large enough and extend far enough, and (3) it should be known where all dining areas will eventually be.

If these points are considered, the kitchen will be able to expand as needs arise with a minimum of effort and expense.—**Lendal H. Kotschevar, Ph.D.,** Chairman, Home Economics Department, Montana State University, Missoula, Mont.

Plan New Guides to Good Nutrition

Basic Seven Food Groups To Be Simplified

One plan for simplifying the Basic Seven food groups consists of a chart divided into four groups of protective foods. It guides individuals to a selection of foods balanced in respect to all nutrients except calories. The average consumer does not appear to need encouragement in selecting high energy foods.

Only two food groups could be used as a nutrition guide. They might consist of energy and protective foods, portrayed on balance pans of a set of scales. By studying such a chart the homemaker can see that a balancing of the two groups is necessary in an adequate diet.

Guides of good nutrition have been adopted in several countries, all of which follow the Basic Seven method of classifying foods into groups based on nutritive value.

The two-group plan would be particularly useful among people with limited knowledge and interest in nutrition. The four-group plan would be most suitable for the U.S. and other countries similarly situated in regard to food supplies and level of nutrition.—**Olive B. Hayes,** Department of Nutrition, Harvard School of Public Health, Cambridge, Mass.

New Kitchen Equipment Must Reduce Number of Employees Needed

Break from Tradition Necessary

The food service industry must devise equipment that will effectively reduce the number of employees needed in both preparation and service, since payroll costs are rising. Once this equipment is developed, food service people must accept and use these new devices.

Among recent developments are a tea urn which automatically brews a liquid concentrate of tea, a deep fat fryer, operating under pressure, which may reduce cooking time 65 percent, a new oven providing high heat for quick cookery of many foods, and equipment using the infra-red spectrum for cooking and warming. The use of gamma rays in processing is being studied.—**Leslie W.**

Scott, Director of Division of Hotel, Restaurant and General Institutional Management, Michigan State University, East Lansing, Mich.

Lack of Understanding Responsible For Neglect of Low Sodium Diets

Diet Booklet Overlooks Patient Needs and Knowledge

Many heart patients fail to follow their low sodium diets. An interview with patients using a booklet on planning low sodium meals disclosed that many were unable to understand and carry out the diet instructions given.

Some diets involved such radical changes in meal planning that patients were unable to follow them. There was not enough explanatory material about the principles of the diet. Frequently the test of acceptable food was how salty it was.

New booklets should receive careful pre-tests to eliminate misunderstanding and confusion. Diet materials should take into account the methods people normally use to plan and regulate their food intake.—**Herbert Caron, Ph.D.**, Social Psychologist, Heart Disease Control Program, Division of Special Health Services, Department of Health, Education and Welfare, Washington, D.C.

Immediate and Future Needs Important in Buying Beef

Portion Cost Knowledge Important

The food service operator must utilize all items from carcass and primal cuts of beef. He must plan for immediate use and for effective utilization in subsequent meals, and must also carefully consider the dollar value of the remaining items.

To evaluate and control his financial position, he must know portion costs. When calculated costs per portion were compared among grades and methods of purchase, results showed that the portion cost of top round from fabricated beef was appreciably less than that of top round prepared from carcass beef and primal cuts. The cost of rolled rib from primal cuts was considerably less per portion than the rib prepared from carcass beef or fabricated rolled rib.

Purchase price per pound was not an accurate index of the cost per portion.—**Captain Marian J. Hayton, USAF** (WMSC), Food Service Officer, USAF Hospital, Wright-Patterson Air Force Base, O.

Above: New ADA president is Mrs. Winifred Howard Erickson (l.), director, department of dietetics, Ancker Hospital, St. Paul, Minn. President-elect is Lucille M. Refshauge, director, department of dietetics, Hartford (Conn.) Hospital.

Food Service Supervisor Must Be Carefully Trained

On-the-Job Training Essential

A planned program, a trained teaching staff, and sufficient time to do a good job of training, are essential for success in training the food service supervisor.

Much time must be given to on-the-job training. The food service supervisor is a student and is not to be used as another employee. Every member of the staff carries a responsibility in his training.

The supervisor must be observant and able to assume responsibility. He must understand the job, be able to teach and sell on the job, and must be interested in methods of improvement.—**Elizabeth Perry**, Assistant Superintendent and Chief Dietitian, Cleveland City Hospital.

Below: Officers of the ADA for 1955-56 are (l. to r.): Marguerite L. Pettee, speaker of the house of delegates, nutritionist at the University of Colorado Medical School, Denver; Mary Ellen Johnson, secretary, educational director of dietetic internships at Colorado State Hospital, Pueblo; and Doris Johnson, treasurer, director of the department of dietetics, Grace-New Haven Community Hospital, New Haven, Conn.

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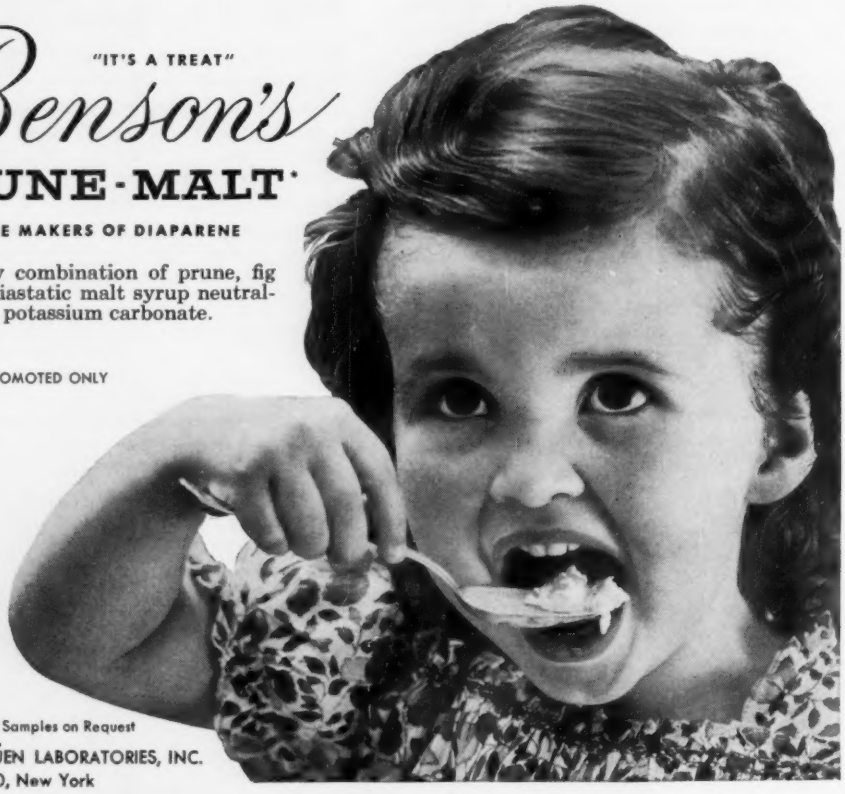

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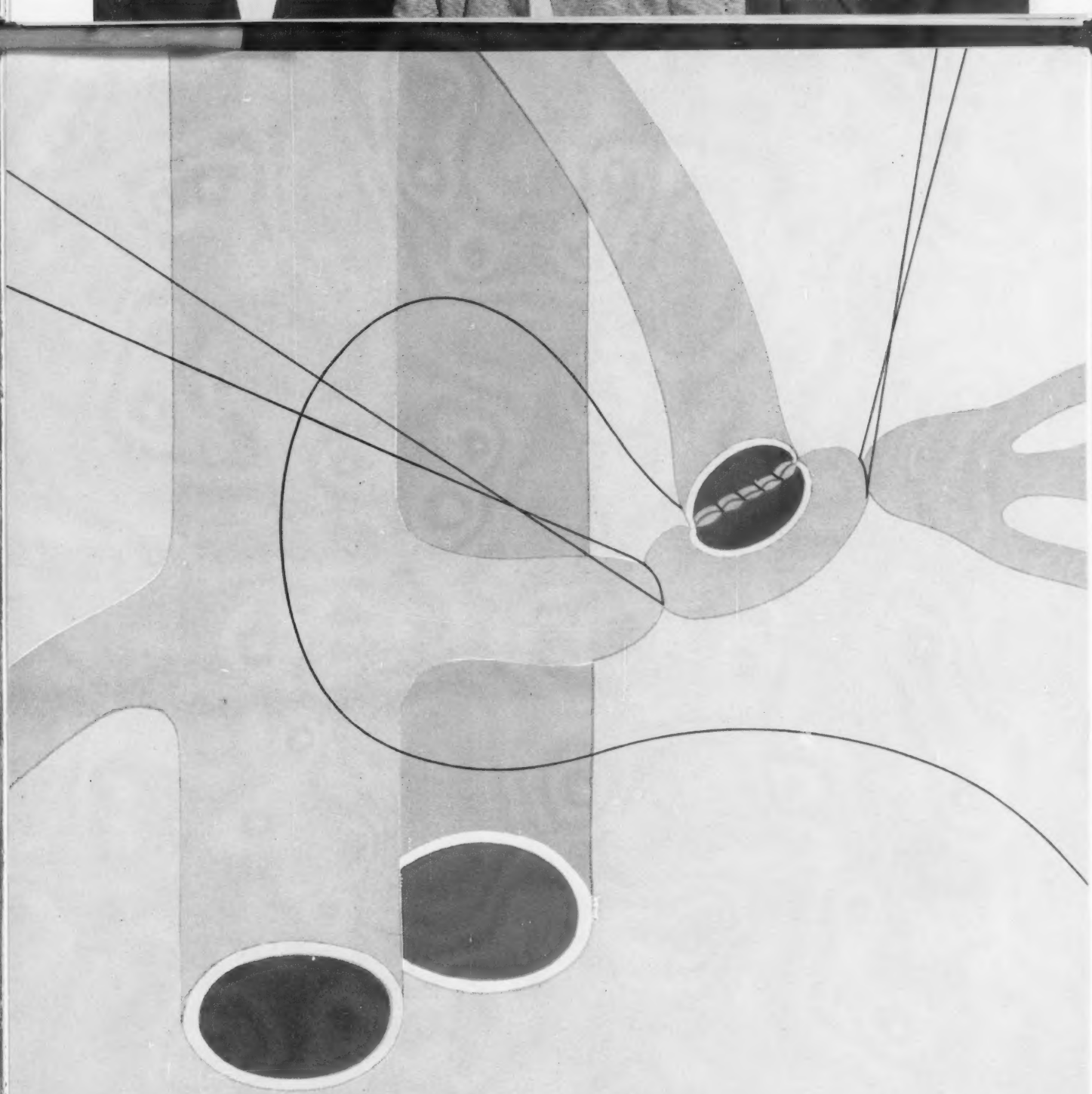

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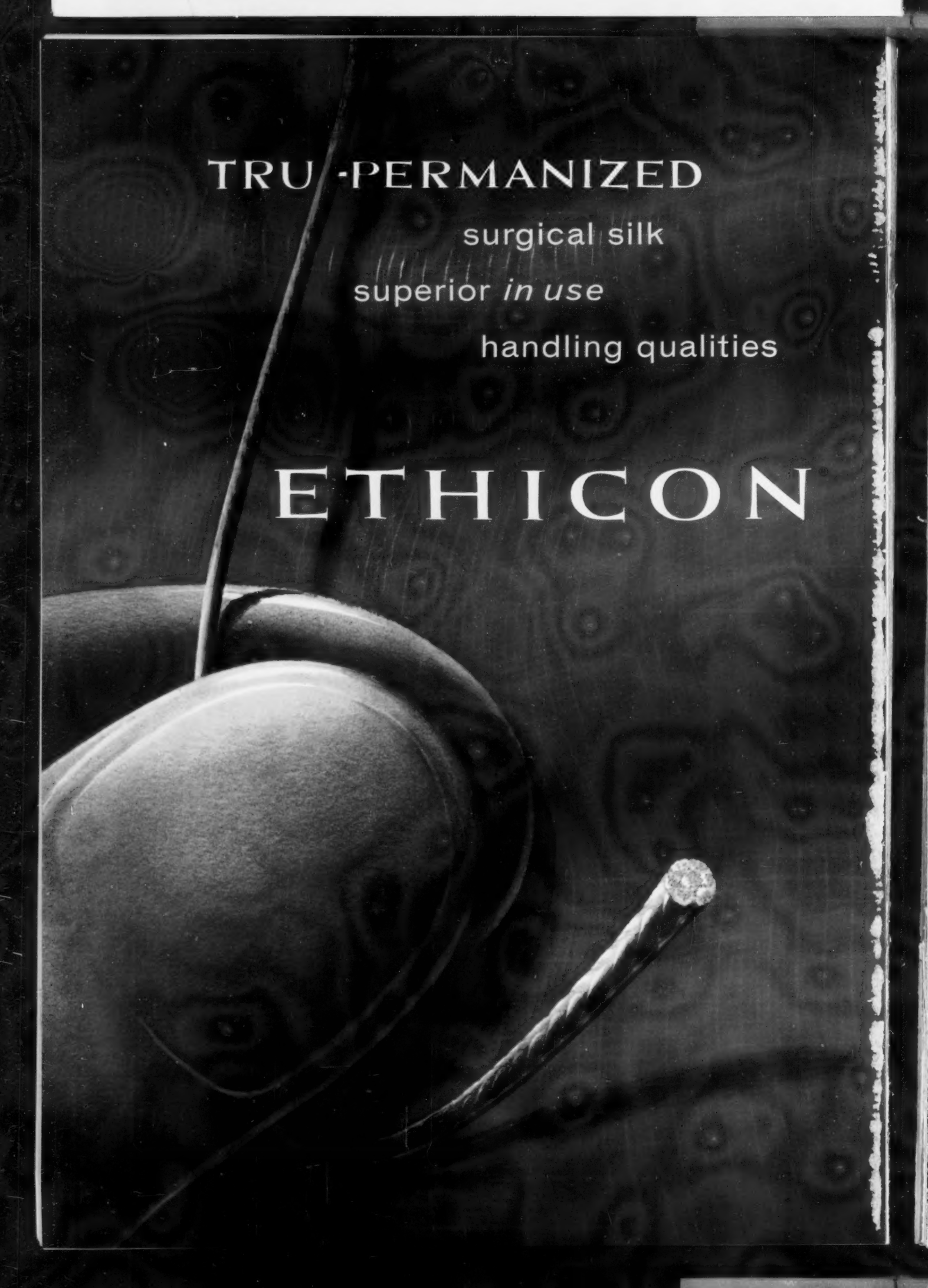
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New association officers (l. to r.): Mrs. Byron Axtell, administrator, Axtell Osteopathic Hospital, Princeton, Mo., secretary-treasurer; Philip Rosenthal, administrator, Metropolitan Hospital, Philadelphia, president-elect; Mrs. Alixe P. Nuzum, administrator, Des Moines (Ia.) General Hospital, president; Heber Grant, administrator, Burbank (Calif.) Hospital, first vice-president; Irvin Biggs, administrator, Rocky Mountain Osteopathic Hospital, Denver, Colo., second vice-president. Mrs Nuzum succeeded Keith Bowker, administrator, Flint (Mich.) Ostepathic Hospital.

Osteopathic Hospital Association Convenes

• *Administrators and staff members from osteopathic hospitals met in Washington, D.C., October 30 to November 2, for the annual convention of the American Osteopathic Hospital Association. Abstracts of selected papers are presented here in TOPICS' report.*

Creative Thinking Essential To Good Management

Right Emotional Atmosphere Must Be Present

Management's capacity for creative thinking is one of the most valuable assets a hospital can have.

The creative force in the supervisor need not be developed, because it is already there. What it requires is an atmosphere in which it may work freely. Creative thinking demands a genuinely free exchange of information among people at different levels of authority. The emergency approach discourages creativity. Likewise, a group's understanding about the results of failure is an exceedingly powerful force in determining creative potential.

Creative thinking involves sensing a problem, preparing data on it, incubating or mulling it over, recognizing the solution, and verifying or testing the solution through control.

The right emotional atmosphere is essential for creativity to function most effectively. Factors contributing to that atmosphere are availability of information, not too unremitting work pressure, refusal to depend exclusively on transmitting information through channels, and understanding of the hospital's official policy of the consequences of failure. The necessity of always being right can stifle creativity.

Our big problem in hospital management controls is to develop the ability to think in all our personnel, thereby creating an understanding why controls are necessary and that reports are a means to see whether the controls are functioning.—**E. L. Herbert,** Administrator, Normandy Osteopathic Hospital, St. Louis.

County Hospital Expansion Great in Past Ten Years

Hospitals Should Review By-Laws Every Three Years

Probably no group in the whole hospital field has grown as much as county hospitals in the last 10 years. County groups are trying to make their hospitals more than homes for the aged.

Administrators of county hospitals work under handicaps not faced by most administrators. They may arise from antiquated laws, accreditation and Blue Cross problems, poor credit risks, politically appointed employees, etc.

Iowa has probably the smoothest, yet most phenomenal growth in county hospitals of any Midwestern state. In Iowa the county treasurer and county attorney are ex-officio members of the board of trustees. They don't always attend the meetings, but when they do, the practice certainly makes for sound financial understanding.

Properly written by-laws, covering every phase of the operation and organization of a county hospital, can save, if not solve, many problems. Every hospital should review and revise its by-laws at least every three years. The medico-legal picture is changing so rapidly that we must not be antiquated in our regulations and controls.

When we set up the first two-staff hospital in the state of Missouri, by-laws were written which could be adopted

(Continued on next page)

Discussing small hospital problems at the problem clinics were (l. to r.): Mrs. Margaret Petersen (back to camera), administrator, Albuquerque, (N. Mex.) Osteopathic Hospital; J. P. Oswald, M.D., Civic Center Hospital, Oakland, Calif.; James F. Moran, administrator, Riverside Hospital, Wilmington, Del.; Louis Chess, administrator, Flint (Mich.) General Hospital; Dale C. Martin, superintendent, Jackson (Mich.) Osteopathic Hospital; Lorene Reed, administrator, McCormick Hospital, Moberly, Mo.; William Maschal, administrator, Sandusky (O.) Memorial Hospital; Mrs. Byron Axtell, administrator, Axtell Osteopathic Hospital, Princeton, Mo.; Karl Greenlee, administrator, Wilden Osteopathic Hospital, Des Moines.

by both medical and osteopathic staffs. Now each staff meets separately once a month, as well as meeting with the liaison committee each month. Problems have been handled within the staff organization. The results: improved service to patients and better hospital relations.—**Forst Ostrander**, Hospital Consultant, Hinsdale, Ill.

Labor Representative Suggests Ways To Improve Hospital Management

Says Color and Class Lines Must Be Eliminated

Hospitals should consider the following devices to improve their services and increase public understanding:

1. Adequate representation of consumers (including labor) on their boards and committees.
2. Consumer or patient advisory committees to the administrator.
3. Institutes in human relations for the entire staff—including physicians.
4. Organized "come-see" tours of hospital facilities for the people of the community.
5. Educational programs, through appropriate channels, in the community at large, on hospital care, objectives, philosophy, operating procedures, budgets, and other important subjects.

It's time for hospitals to wipe out color and class lines. The ward must go—for both medical and democratic reasons. It was and is an indignity to both the patient and the hospital.

Who will pay the bill? The people will—now through hospital fund drives, nonprofit prepayment plans, collective bargaining, and taxes, and eventually through some form of social insurance based upon earnings and governmental-employer-employee responsibility.—**Leo Perlis**, National Director, CIO Community Services Committee, New York City.

Number of Hospital Aides Tripled Since 1943

37 States Have Training Programs; Project Favored by Personnel

The number of nursing aides in general hospitals has almost tripled since 1943—from 34,000 then to 117,000 in 1954.

The need for a training program for aides was seen by several groups at about the same time, in 1952. The Public Health Service was asked by the Health Resources Advisory Committee to investigate the need and write a handbook for aides and an instructor's guide. The American Hospital Association underwrote the publication of the handbook, and the National League for Nursing arranged to conduct teacher training institutes.

Every state now has a committee, with representatives of nurses, hospitals, and vocational education, to guide the aide project, and 37 states have established training programs.

The basic plan is to send one to four teachers from a state to a regional institute. They come back and arrange local workshops to teach the persons who will instruct the aides. In the first 18 months of the program—to August, 1955—1,350 hospitals and nursing homes have sent personnel to teaching institutes. These hospitals employ about 72,000 aides, or almost two-thirds of all aides working in hospitals.

When possible, hospitals select supervisors or head nurses to teach the aides, but often they have had to use staff nurses or even practice nurses. The program works best in a hospital in which everyone understands and prepares for it. Administrators, doctors, patients, aides, and instructors all have expressed their enthusiasm and satisfaction.—**Margaret G. Arnstein, R.N.**, Chief, Division of Nursing Resources, U.S. Public Health Service, Washington, D.C.

Fred McNamara (l.) assistant chief, Bureau of the Budget, Washington, D. C., discussed the federal hospital programs at the meeting. Also at the speakers' table are Philip Rosenthal (center), administrator, Metropolitan Hospital, Philadelphia, and Forst Ostrander, hospital consultant, Hinsdale, Ill. Mr. Ostrander, who followed Mr. McNamara on program, discussed county hospital organization.

American College of Osteopathic Hospital Administrators new officers (l. to r.): George A. Fuller, Jr., administrator, Lakeside Hospital, Kansas City, Mo., trustee; Heber Grant, administrator, Burbank (Calif.) Hospital, president; and A. C. Parmenter, administrator, Still Osteopathic Hospital, Des Moines, Ia., vice-president. Re-elected trustees (not shown) are Philip Rosenthal, Irvin Biggs, and B. Allan Sumner, Park View Hospital, Los Angeles. Hospital association and college met in conjunction with convention of American College of Osteopathic Surgeons.

Above: Edwin L. Crosby, M.D. (l.), executive director, American Hospital Association, Chicago, one of the principal speakers, with W. W. Stadel, M.D., superintendent, San Diego County General Hospital, president-elect of the California association, and A. E. Maffly, administrator, Herrick Memorial Hospital, Berkeley, and president-elect, Association of Western Hospitals.

Problem Clinics Popular at Meeting of California Hospital Association

● Over 500 attended the annual meeting of the California Hospital Association in San Diego, which had as its theme, "Bring Your Problems." Jam-packed problem clinics were popular.

Edwin L. Crosby, M.D., executive director, American Hospital Association, Chicago, who had left Washington the day before to be present, warned that Secretary of Health, Education, and Welfare Marion B. Folsom told him socialized medicine in the United States is a possibility unless present health insurance plans are furthered. Dr. Crosby pointed out the urgent need for legislation to aid the nation's indigents.

To add emphasis to Dr. Crosby's warning, George U. Wood, administrator, Peralta Hospital, Oakland, who had just returned from an extended trip to Europe, told a large group of doctors from the San Diego County Medical Society, step by step, the manner in which nations slip into complete socialization of their health functions. In conclusion, Mr. Wood said, "Since every government system of medicine was instituted in a period of depression, make plans now for such a situation arising. It *can* happen here."

Long-term care of patients is the most acute problem of hospitals today, said Gordon R. Cumming, director, Bureau of Hospitals, California State Department of Public Health. "People are just living longer than they used to," he declared. "This is bringing about a change of operation. With the advent of new, effective drugs and modern technics, the need for acute hospital beds is shrinking. We just don't need them as we once did." Cumming, who also received the association's award of merit for outstanding work for the year, concluded that the immediate need is for facilities for convalescent care.

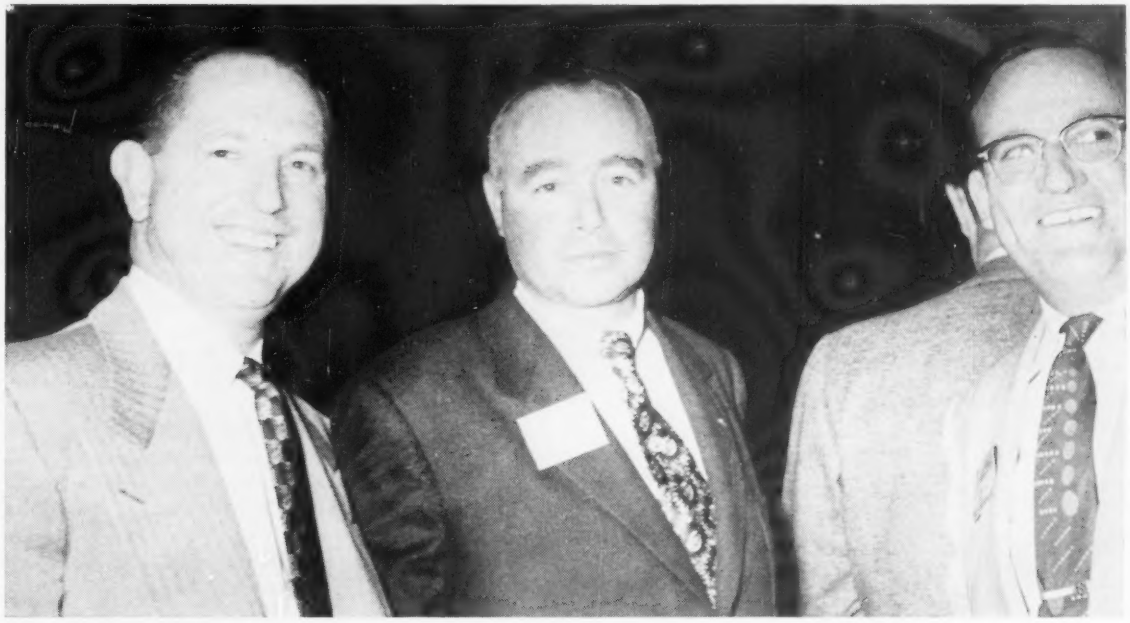
An international flavor was cast over the proceedings by Dr. Gustavo Aubanel of Tijuana, Baja California, Mexico. He told a group of 40 California Hospital Association officials and their wives that "sickness and disease do not recognize international boundaries." He outlined some of the history of Mexican medicine and pointed out, "Many of your American drugs were used by the ancient Mayan priests. Rauwolfia, now popular for hypertension, has been found in ancient tombs and was in constant use." Dr. Aubanel, municipal president of Tijuana, was host at a pre-convention banquet held south of the border.

A warning that "the doctors will get you if you don't watch out" was sounded by Alfred E. Maffly, administrator, Herrick Hospital, Berkeley, and chairman of the council on professional practices. He reported on a resolution

(Continued on next page)

Below: New president Fred W. Moore (l.), administrator, Rideout Memorial Hospital, Marysville, gets a few tips from a former president, Thomas P. Langdon, administrator, Hahnemann Hospital, San Francisco.

Left: George Nelson (l.), administrator, Glendale Sanitarium, with Avery Millard, executive director, California Hospital Association, San Francisco.



Above: Enjoying the meeting were (l. to r.): James Ludlum, Los Angeles, attorney, California Hospital Association; Ralph J. Hromadka, administrator, Santa Monica Hospital, and Frank MacDougall, administrator, Sharp Memorial Hospital, San Diego.

Left: Paul C. Elliott, administrator, Hollywood Presbyterian Hospital, Los Angeles, immediate past president of the association.

Above: Gene Salisbury (l.), associate director, California Public Health League, San Francisco, stopped to talk with Jean Orban, California Physicians Service.

Below: Among the auxiliary members who acted as hostesses were Mrs. Raymond Low (l.) and Mrs. Bernard Lagasse, Jr., both members of the auxiliary at Mercy Hospital, San Diego

passed by the California Medical Association which urged that hospitals adopt a cost basis for their charges. Maffly stated that the intent of the resolution would be met "if hospitals would discontinue the traditional method of undercharging for hospital rooms and overcharging for laboratory and other services."

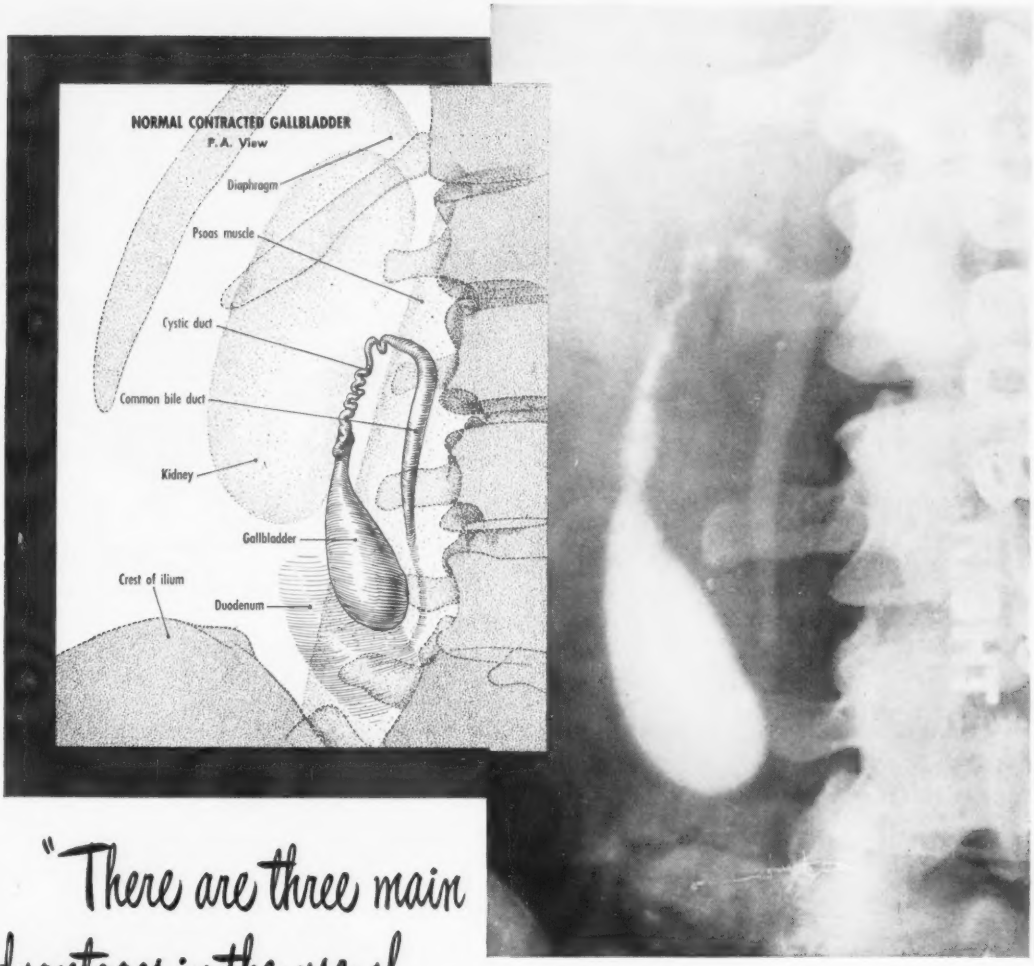
The jury brought in a verdict of $65,000 at the mock malpractice trial, a feature of the annual banquet. With a cast of doctors and lawyers, headed by Louis Regan, M.D., L.L.B., attorney and writer on hospital law, every detail of an actual trial was unfolded for delegates. Although the event was scheduled for amusement only, many throughout the audience scribbled furiously in their notebooks as point after point was unfolded in the course of the mock trial.

The traditional "free" evening was celebrated by a genuine Hawaiian luau held on an island in San Diego bay. Delegates were taken to the island in speed boats. A full moon and warm evening added the tropical touch. The Kona Kai Club on the island was specially decorated in authentic Polynesian motif.

Fred W. Moore, administrator, Rideout Memorial Hospital, Marysville, is the new president. He succeeded Paul C. Elliott, administrator, Hollywood Presbyterian Hospital, Los Angeles. W. W. Stadel, M.D., superintendent, San Diego County General Hospital, was named president-elect. Clifton Linville, administrator, Fresno Hospital, went in as treasurer. Trustees elected were William S. Weeks, administrator, Marin General Hospital, San Rafael; B. J. Caldwell, administrator, Pomona Valley Community Hospital, and George B. Nelson, administrator, Glendale Sanitarium and Hospital, Glendale. Delegates named to the American Hospital Association and to the Association of Western Hospitals were George U. Wood; Ritz E. Heerman, general manager, Lutheran Hospital Society of Southern California, Los Angeles; D. L. Braskamp, administrator, Alhambra Community Hospital, Alhambra; Paul C. Elliott; John H. Gorby, administrator, La Mesa Community Hospital, La Mesa; A. E. Maffly, and Ralph L. Ryan, administrator, Lillian Collins Hospital, Turlock.

San Jose was selected as the site of the 1956 meeting.

Left: L. to r.: Leverett F. Bristol, administrator, Coronado Hospital; Kevin Hegerty, assistant administrator, Sharp Memorial Hospital, San Diego; Joseph Zem, administrator, St. Luke's Hospital, San Francisco; and G. C. Crary, administrator, Scripps Memorial Hospital, La Jolla.



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Buckstein, Jacob: The Digestive Tract in Roentgenology. Philadelphia, J. B. Lippincott Co., 2nd ed., 1953, vol. 2, p. 1003.

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Co-winners of an emergency patient removal and fire fighting competition in Chicago, Presbyterian Hospital team is shown receiving an award from the Greater Chicago Safety Council, presented by Rita Dimitri, star of the musical, "Can Can." At extreme left is Lt. Robert McGrath of the Chicago Fire Prevention Bureau, who instructed the 16 teams taking part in the competition. At right is Stephen Manheimer, M.D., president, Chicago Hospital Council and director, Mount Sinai Hospital, Chicago. Awards were presented at a special luncheon held in recognition of the nurses who participated. The other award winner was the team from South Chicago Community Hospital.

National Bureau of Standards Opens Radiochemistry Lab

A new radiochemistry laboratory for use in preparing and distributing standard samples of radioactive materials has been established at the National Bureau of Standards in Washington. It will include equipment for remote control operations under chemical hoods, specially built lead and concrete protective shieldings, and a system for proper disposition of radioactivity from the exhausts of the chemical hoods.

The resources of this laboratory are expected to expedite greatly the Bureau's program of radioactive sample distribution.

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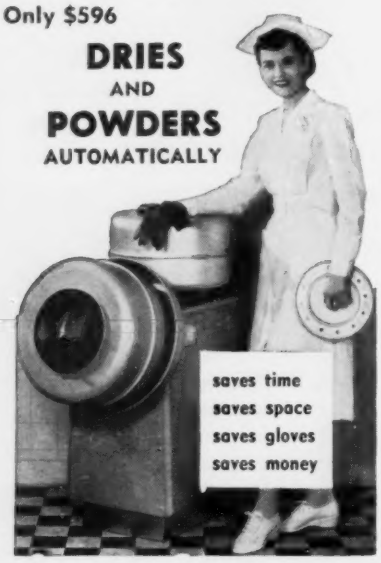

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VA Keeps Mentally Sick Veterans Out of Hospitals

VA mental hygiene clinics are keeping an average of 2,200 mentally sick veterans out of hospitals every year.

Many veterans are engaged in useful productive work while receiving treatment, and generally improve sufficiently to end their outpatient treatments.

Cost of treating the 2,200 in the mental hygiene clinic an average of once a week for one year is roughly $1,000,000. The cost of treating the same number of patients in a neuropsychiatric hospital is about $5,000,000 per year.

The VA operates 62 mental hygiene clinics throughout the United States —the largest network of outpatient clinics under one management in the country.

More Children Born In Hospitals

More children in the United States are being born in hospitals, Metropolitan Life Insurance Co. reports.

Lately the number has exceeded 3,500,000 annually. In 1952, the last year for which official data are available, better than nine out of every 10 births were delivered in hospitals.

The proportion of hospitalized births in the white populations increased from 59.9 to 95:7 percent between 1940 and 1952, and among nonwhites from 26.7 to 66.4 percent.

Hospital Admittance In Older Men

About one man in every seven—age 60 or over, is admitted to a hospital in the course of a year, according to a Metropolitan Life Insurance Co. personnel study.

Proportion is higher than the rate among those at ages 45 to 59, and about twice the rate among those under 45 years of age.

For the entire age range of 60 and over, the average length of each hospital stay was 18.1 days. This is one and one-half times the average for ages 45 to 59, and nearly twice that for ages under 45.

Staff Changes at AHA Announced

Three staff changes at the AHA were announced recently. Edmond J. Lanigan has joined the staff as coordinator of association services. James E. Hague is now coordinator of publications, and Daniel S. Schechter, assistant public relations director since July 1954, has been promoted to public relations specialist of the association.

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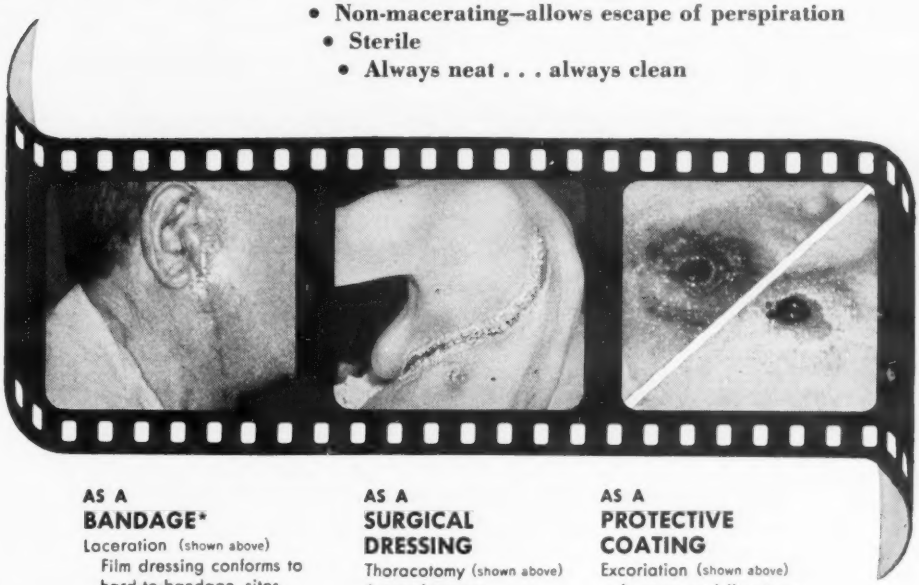


AS A BANDAGE*

Laceration (shown above)
Film dressing conforms to hard-to-bandage sites
Scalp wounds
Abrasions and Burns
Skin eruptions

*If hemostasis is complete, use Aeroplast alone. If incomplete, apply one coat of Aeroplast, a layer of gauze, then spray gauze and surrounding skin area with Aeroplast.

AS A SURGICAL DRESSING

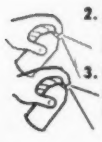
Thoracotomy (shown above)
Appendectomy
Herniorrhaphy
Major burns
Vein ligations
Mastectomy
Decubitus ulcers

AS A PROTECTIVE COATING

Excoriation (shown above)
Area around ileostomy cleared in 24 hours.
To prevent excoriation
To control dermatologic distress, e.g., itching or burning as in sunburn or poison ivy.
Under skintight casts
Episiotomy

easy to apply

1. **Spray a light film onto aseptic dry wound from a distance of 6 to 12 in.**
   Cover adjacent area of intact skin to provide anchorage.
   Hemostasis should be complete.
   May be applied over sutures.
2. **Allow film to dry for 30 seconds.** (sufficient time for the acetone solvent to evaporate)
3. **Repeat "spray and let dry" procedure (steps 1 and 2 above) two more times.**



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1. Vibesate (Aeroplast) — New and Nonofficial Remedies, 1955, p. 541.

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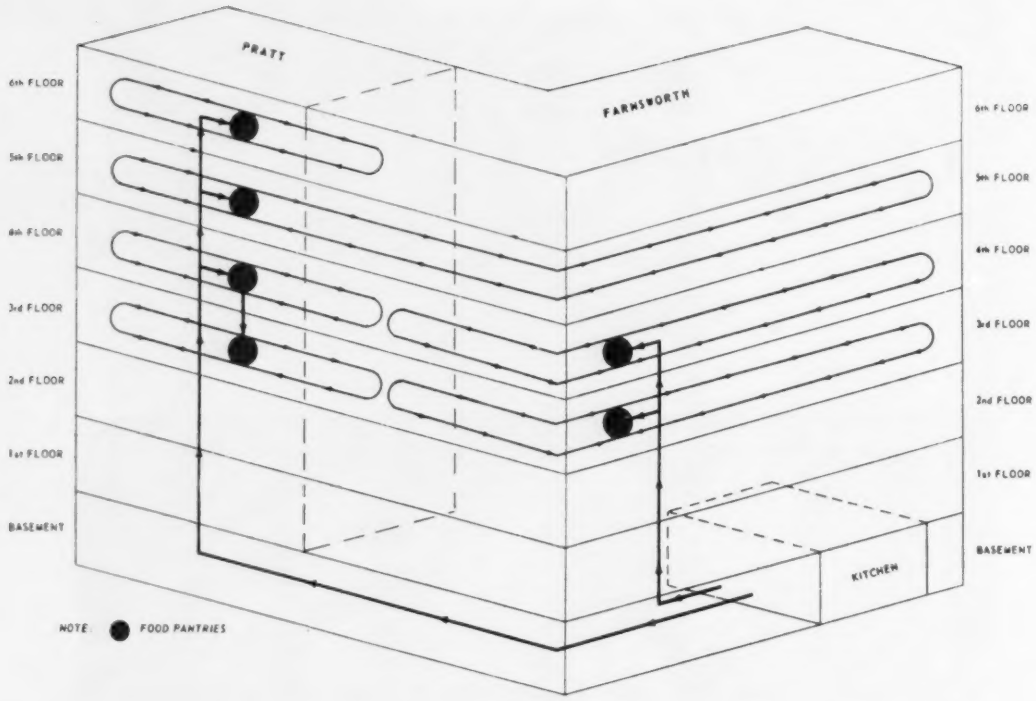


PRESENT METHOD OF DISTRIBUTING MEALS - TYPICAL FLOOR

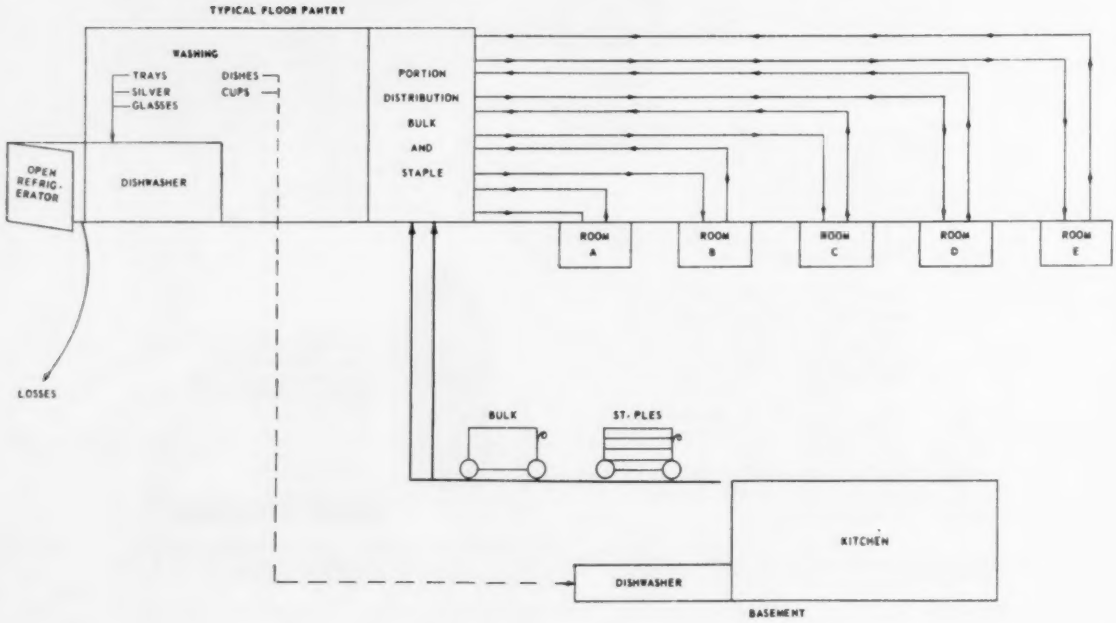


Exhibit I. Present food system.

Case Studies In Determining Space Requirements – *Part II*

By John G. Steinle
Cresap, McCormick & Paget
Management Consultants
New York City

Programing a Dietary Layout

● A policy decision has been made to convert the present bulk food system to a central tray system. This decision was made principally because of the present high cost of serving food from the kitchen to the patient. This cost (the serving of food only) varies, according to nursing unit, from 25 to 35 cents for patient meal.

PRESENT SYSTEM

All food is prepared in the central kitchen. It is transported to the floor in bulk food carts. In the floor kitchen, trays are set up before the prepared food arrives. The tray is completed from "bulk food carts" and carried to the patient. Exhibit 1 graphically describes the present food system.

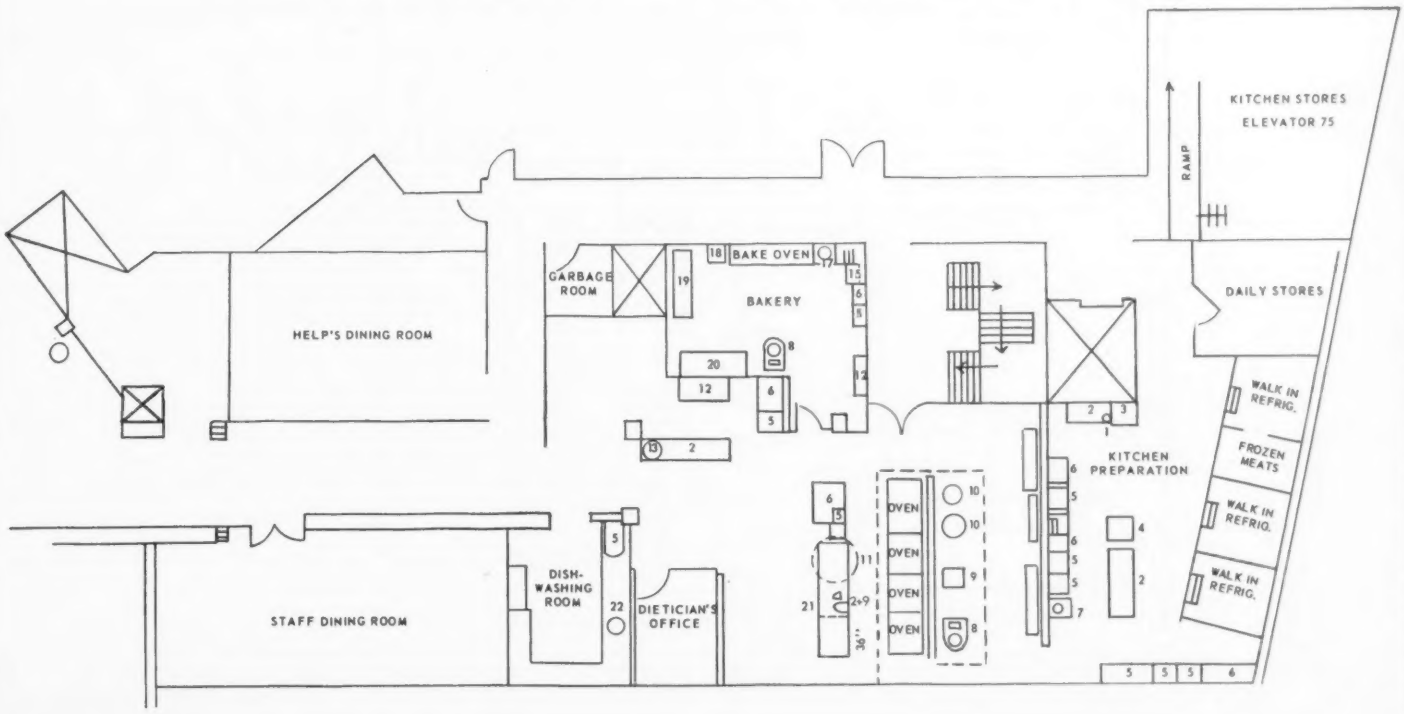
The cost of construction of the central kitchen was exceptionally low. Consequently, it has certain space limitations which made expansion of activity difficult. This is inherent in a central tray assembly. Primarily, the kitchen was planned according to the following division of activities:

1. Preparation
2. Cooking
3. Baking
4. Supervision (dietitians' office)
5. Dishwashing
6. Kitchen personnel dining
7. Staff dining.

Exhibit 2 shows the present kitchen layout. Detail is shown by code number, keyed to the items listed below.

(continued on next page)

Exhibit 2. Present kitchen layout. Code number key: 1. Can opener; 2. Work table; 3. Meat block; 4. Meat slicer; 5. Sink; 6. Work table connect to sink; 7. Potato peeler; 8. Mixer; 9. Steamer; 10. Steam kettle; 11. Overhead pot rack; 12. Refrigerator; 13. Coffee urn; 14. Frozen food unit—four compartments; 15. Storage table; 16. Pot rack; 17. Small range; 18. Rack cabinet; 19. Combination work table, shelf storage; 20. Work table with flour bins and storage; 21. Small steam table; 21a. Two 14" covers; 22. Salvajar.



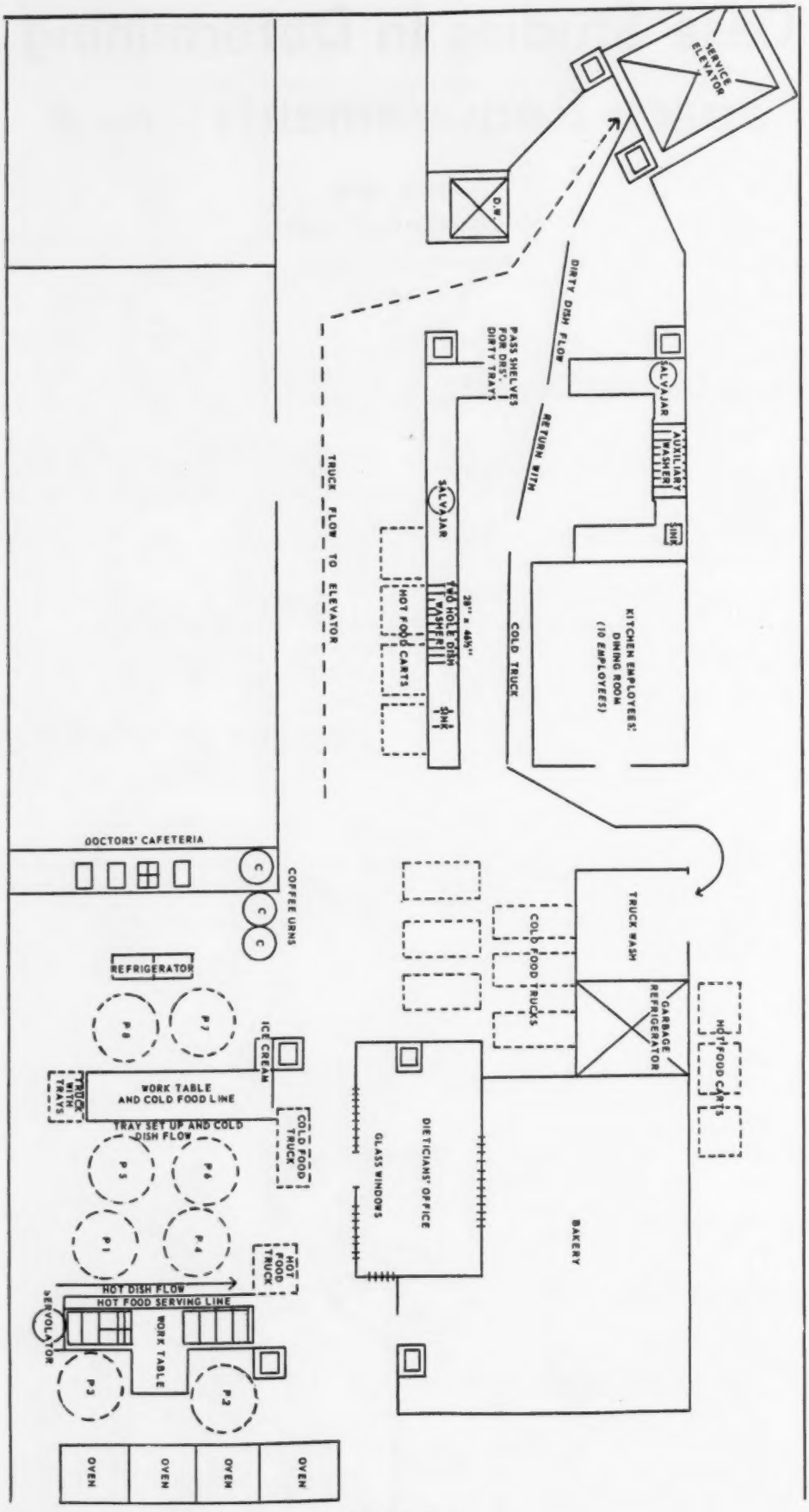


Exhibit III. Plan A.

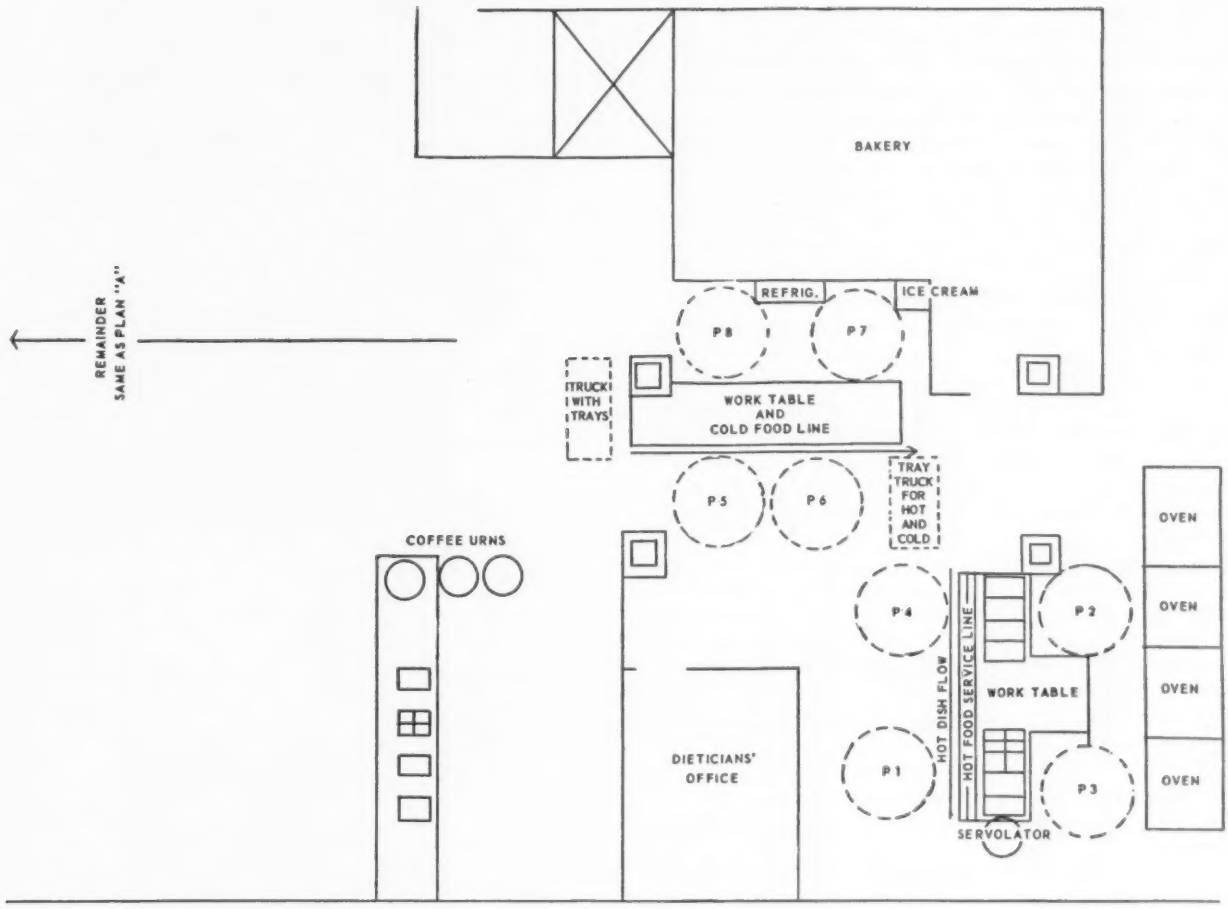


Exhibit IV. Plan B. Code for Plan A. and B. is as follows: P1. Dietitian—who reads diet list and supervises hot food assemblage. P2. Cook—who serves hot foods. P3. Cook—who serves hot foods. P4. Diet maid—who passes hot plate and loads hot cart. P5. Assistant dietitian—who reads diet and supervises cold line. P6. Diet maid—who passes tray and assists salad make-up in tray set-up and loads cart. P7. Salad girl—who prepares salad and assists in tray set-up. P8. Salad girl—same as P7. Advantages and disadvantages are explained on next page.

SPACE REQUIREMENTS Continued

PROPOSED METHOD

For central tray systems, a substantial amount of space generally is necessary for the loading of the trays in, or adjacent to, the main kitchen. In hospitals over 100 beds that have a central tray system, there are separate "assembly lines" for hot and for cold foods.

1. Hot food assembly. Trays usually are placed on an "assembly line." The tray is moved forward manually or by a conveyor belt past service pans from which food is ladled. The size of the hot food line depends on the variety of foods being served, not on the total number of meals. Serving trays usually can be refilled easily and quickly from ovens and steamers. Service pans usually are 20" x 12", with a maximum depth of 8". These modules can be divided into half sizes of 20" x 6", or quarter sizes of 10" x 6".

To estimate the size of the hot food line, menus for one month were analyzed. The following breakdown, representing an evening meal, illustrates the way in which the analysis was made.

A Typical Evening Meal And Serving Requirements in Modules

	Requirements	
	Number of Modules	Size in Inches
Minced tenderloin loaf—s.f., f.f., (salt-free, fat-free)	1	20 x 12
Baked salmon steak—bland	1	20 x 12
Minced tenderloin loaf—regular	1	20 x 12
Roast pork—regular	1	20 x 12
Potatoes, oven brown—regular	½	10 x 12
Potatoes, mashed—s.f., f.f.	½	10 x 12
Kale, buttered—regular	½	10 x 12
Minced vegetables, buttered—regular	½	10 x 12
Kale—s.f., f.f.	¼	10 x 6
Gravy, onion	¼	10 x 6
Gravy, brown	¼	10 x 6
Kale, pureed	¼	10 x 6

For the above, space for seven modules must be provided.

(Continued on next page)

It was found that the maximum number of modules during the month studied was eight. Manufacturers advised that a steam table able to accommodate eight 20" x 12" units should be approximately 14 feet in length.

2. Cold food assembly. The space requirements for this unit will vary according to the type of tray conveyor utilized. In some systems, salads can be stored in a "cold cart" before the cart is taken to the floor. In other systems, the salad must be prepared, refrigerated until ready for serving, and subsequently loaded on the tray for service to the patient.

a. *For separate "hot" and "cold" conveyor trucks (Toastmaster system).* The trays can be set up with salad in the cool section of the truck. Cold desserts can be stored in the cold section.

b. *For heated trucks with nonheated sections for tray.* Salads should be refrigerated until the hot tray is assembled. The salad then can be put in the nonheated section.

c. *For trucks containing both heated and refrigerated sections.* The trays can be assembled with salads and cold desserts at the same time or before the hot plates are assembled.

It was found that two people preparing salad trays require a minimum of 7' x 4' for preparation of salads and for serving salads, if they are to be loaded on trays at this point. Additional space would be required for refrigeration, if this were necessary, depending on the system used.

It also was found that an area of 4' x 3' would be necessary to serve desserts. An ice cream serving bin was found to be desirable near this serving area.

3. Clean-up. At present, dishes are scraped and stacked in the floor pantries. Stacked dishes are sent to the central dishwashing room. Trays, silver, and glasses are washed on the floor. With deactivation of floor serving pantries and the centralization of diet personnel, all dishes and trays should come to the central dishwashing room. Central dishwashing would:

a. Scrape all dishes and trays.

b. Rinse dishes.

c. Place trays, dishes, glasses, and silver in racks.

d. Wash trays, dishes, glasses, and silver.

A study was made of the total load for the four steps above for the evening meals for two days. The average load was as follows:

Dishes 10"	131
Dishes 8"	78
Dishes 6"	69
Sauce bowls	428
Soup bowls	121
Salad plates	207
Cups	214
Other	96
Trays	156
Knives	164
Spoons	329
Forks	187

The unit currently in use has a rated capacity somewhat below this requirement: one tank, push-through; 1 horsepower, 25-gallon wash tank; 180-gallon pump capacity; five 20" x 20" rack occupying 28" x 34½" floor space.

The next size, automatic pawl conveyor, occupying 28" x 46½", 1½ horsepower, with a 38-gallon and a 250-gallon pump capacity, with seven 20" x 20" rack capacity, can barely meet the above requirement.

To meet present demand plus foreseeable future expansion, the following dishwashing equipment was decided upon (it should be noted that the present dishwasher was retained; this represented a saving):

a. A 28" x 46½" automatic pawl conveyor, and

b. The present one tank push-through unit as an auxiliary.

PROPOSED WORK FLOW

Having established the workloads and equipment necessary (hot line, cold line, and dishwashing equipment), the next step was to develop an adequate work flow. This was accomplished by making a floor plan of the kitchen according to scale. Templets were made from cardboard, in the same scale used for the kitchen layout, for the hot line, the cold line, various types of carts, the dishwasher, and for the various workers (a 4' diameter was provided as a minimum space). A number of layouts were made from the arrangements of the templets on the floor plan. Exhibits 3 and 4 (on pages 32, 33) show two of these layouts.

FACTORS CONSIDERED IN SELECTING PLAN

In order to decide between the two plans, the following factors were considered:

1. Advantages and disadvantages of the two systems. Plan "A" (Exhibit 3) provides:

a. Relocating the dietitians' office and providing it with sufficient windows to observe the bakery, the dishwashing area, the tray assembly line, the rear of the kitchen, and the staff cafeteria line.

b. The establishment of a staff cafeteria.

c. The providing of pass shelves for the dirty dishes from "staff dining room."

d. Dishwashing directly opposite the service elevator.

e. A separate hot and cold food line which permits efficient loading for any type of food cart.

f. A simple straight-line flow for assembly of trays and movement of carts to the service elevator.

Plan "B" (Exhibit 4) is similar to Plan "A" except that:

a. The dietitians' office remains in present location.

b. The partition between the present dishwashing room and dietitians' office remains intact. This provides a partition from staff cafeteria serving area and rest of kitchen.

c. It places cold food line adjacent to bakery for easy flow of baked desserts.

d. It places hot and cold food line at right angles for simple flow in loading a combination hot and cold truck. For separate hot and cold trucks, the cold line can be reversed so that the line feeds directly into cold trucks parked in adjacent area.

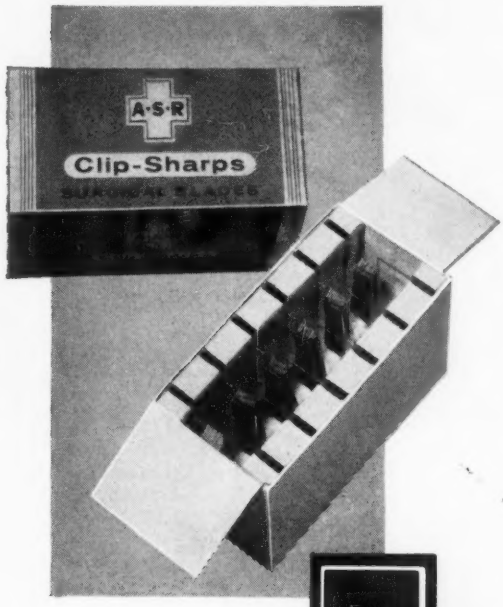
e. The amount of construction is substantially reduced.

2. Relative capital expenditure.

a. Plan "A" was estimated to cost $20,000, including equipment and food carts.

b. Plan "B" was estimated to cost $15,000, including equipment and food carts.

(This is the second in a series of articles on space requirements. The first appeared in the November issue on page 21; the third will appear in the January, 1956, issue.)



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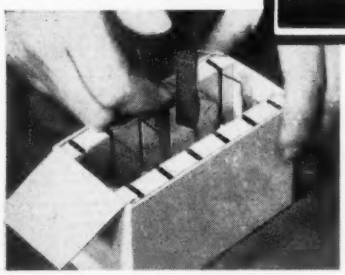
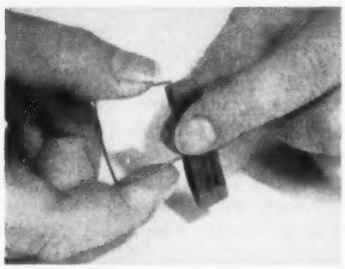
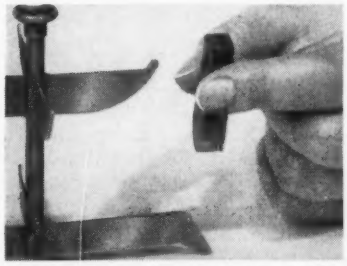
TRADE MARK



Remove cover – hold box in one hand. With other hand lift one wire holder (24 Blades) from box.



Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.



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HT-12

New officers of the Indiana Hospital Association posed with Ralph Haas, (l.), outgoing president, at the annual breakfast for officers and trustees. New president of the group is Sister M. Vetusa, administrator, St. Catherine's Hospital, East Chicago, Ind. Herbert A. Schacht, (r.), administrator, Henry County Hospital, Newcastle, is president-elect.

Indiana Hospital Association Meets October 12-13

In-Service Training Program Should Be Run by the Staff

Administrator Can Help Set Goals

In setting up adult education programs in hospitals, we are getting away from telling these people what they must learn. We want to assist them to determine themselves what they need to know.

We are also trying to get away from the individual lecture and put the program on a group discussion basis. Moreover, we want to help coordinate staff members' professional and personal lives.

To institute such a program, the administrator must be willing to accept constructive criticism. He should gain the cooperation of the entire staff by making it understood that the program is to be run by them. He should also plan to set up a schedule for monthly meetings.

To get the program started, the head nurses and staff nurses should meet with the administrator to set up goals and policies. They should then select an over-all planning committee and an educational committee to find out what topics they want to discuss. It is a good idea to appoint eight program chairmen for an eight-month program.—**Russell Vance**, Consultant and Instructor, Community Services and Adult Education, joint enterprise of the University of Indiana and Purdue University.

Geriatric Medical, Surgical Facilities Should Be in One Place

Re-education of Activities of Daily Living Stressed

In treating geriatric patients, we must provide adequate medical and surgical care during the acute phase of illness, preserve nutritional status, administer to physical, spiritual, and social needs, and establish an active rehabilitation program.

To provide adequate medical and surgical care, the geriatric hospital should have a complete medical staff in every specialty. It is desirable to have all physical facilities, such as x-ray, laboratory and surgery in one place, so that all medical care can be accomplished under the same roof. A geriatric patient seldom suffers from just one disease; so facilities must be available for handling a variety of complications.

Diet for these patients should consist of 1,800 to 2,400 calories, adequate in protein and a little low in carbohydrates and fats. The method of serving used by the dietary department is an important part of rehabilitation. Many patients look forward to meal times as a break in a monotonous existence.

Our rehabilitation program consists of physical therapy, occupational therapy, and re-education in the activities of daily living. Each patient is presented by an intern at an evaluation conference made up of a physiatrist, other physicians on the staff, therapists, nurses, and the administrator. We try to teach each patient to help himself as much as possible—to feed himself, to wash, shave, to use a wheelchair or crutches. A special board fitted with a faucet handle, light switch, and window shade helps the geriatric patient re-learn the everyday activities he may have forgotten.

One special feature at our hospital is the bedding for incontinent patients. Our carpenter has built several beds that look like wooden boxes. These are filled with sawdust made of pine shavings, and the patient lies directly on the sawdust. Advantages of this system are: there is an even distribution of body weight, the sawdust absorbs body excreta, and the incidence of bed sores is a fraction of what it was. The sawdust is changed about every other day. We stress the medical benefits of the use of sawdust, not the saving of personnel and linen.—**Sander Goodman, M.D.**, Assistant Director of Medical Services, County Home and Daniel Drake Memorial Hospital, Cincinnati, O.

Mental Confusion in Older Patients Not Always Due to Senility

Drugs May Cause Disturbances

A major problem in caring for geriatric patients is handling the mental confusion in these patients. However, much of this confusion may be remedied very quickly by restriction of some of the more commonly used drugs.

For example, congestive heart failure is a common geriatric ailment which is treated by restricting sodium in the diet and giving mercurial diuretics. Both treatments disturb the electrolyte balance of the body and lead to mental confusion. Accumulation of digitalis in the body may produce toxic manifestations, one of which is mental

(Continued on next page)

Above: Merle F. Wentz (l.) came from Louisville, Ky., to attend the Indiana meeting. He is assistant to the administrator, United Mine Workers of America. With him are John M. Shaw (center), administrator, Mary Sherman Hospital, Sullivan, Ind., and Al Boulenger, administrator, Good Samaritan Hospital, Vincennes, Ind.

Above: At the social hour preceding the annual banquet, Dorothy G. Adams (l.), administrator, Gibson General Hospital, Princeton, Ind., and Vera A. Mahan, business manager at the same hospital, have a moment for a quiet chat during the social hour.

Above: Indiana State Auxiliary members (l. to r.): Mrs. Howard M. Henderson, St. Vincent's, Indianapolis; Mrs. H. W. Seigle and Mrs. Alfred D. Jenner, Elkhart General Hospital; Mrs. Herman C. Fromer, president of the State Auxiliaries.

Left: Ralph M. Haas, administrator, Montgomery County Culver Union, Crawfordsville and outgoing president of the association, received his past-president's pin and congratulations from Albert G. Hahn, executive secretary.

Right: Stanley E. Giese (l.), administrator, Warren Hospital, Michigan City, and William McAlexander, administrator, Clark County Memorial Hospital, Jeffersonville.

Below: Two more members of the U.M.W. area medical office, Louisville, joined Robert Carithers (r.), assistant superintendent, Methodist Hospital, Indianapolis. They are: Elwood C. Musselman (left), and Charles C. Hampton (center).

Below: Members of the Indiana State Board of Health attended the meeting to act as consultants to visiting administrators. Here Robert L. Rogers, hospital administrative consultant, advises Mrs. Olive De Hart, administrator, Daviess County Hospital, Washington.

Below: During a break in the meetings, Guy W. Spring (l.), executive director, Blue Cross Hospital Service, Indianapolis, chats with Program Chairman Robert W. Morgan, superintendent, Marion County Hospital and Home, Indianapolis.

Martha O'Malley, M.D., (r.), director, Div. of Hospital and Institutional Services, Indiana State Board of Health, Indianapolis, takes time off from her duties as visiting consultant to speak with Mrs. Albert G. Hahn, assistant executive secretary, Indiana Hospital Association.

confusion. A potassium deficiency in the diet may lead to weakness and depression.

Pediatricians know how to gauge the proper dosage of a drug for a small body. The geriatric specialist should remember that while he is dealing with adult bodies, the ability to excrete the drugs is reduced. Thus the dosage should be limited, as a child's is.

This problem of accumulation also may occur with the injudicious use of sedatives and the long use of some antibiotics.

We should also remember that not all shortness of breath is due to congestive heart failure. If the cause is emphysema, exercise is needed rather than bed rest. In such cases, salt restriction and the use of digitalis may set off a whole train of mental symptoms.

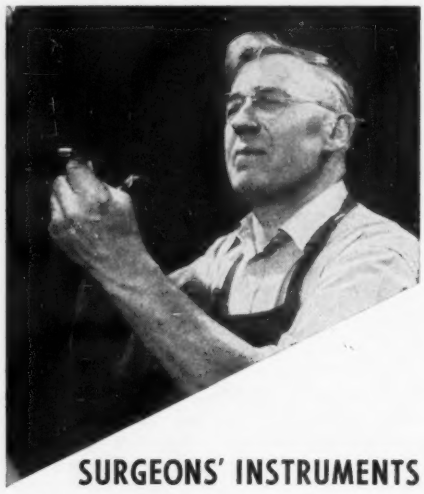
Mental confusion must not always be looked upon as the result of a cerebral accident. Sometimes all that is needed is proper nutrition and electrolyte balance.—**Kenneth G. Kohlstaedt, M.D.,** Eli Lilly Laboratory for Clinical Research, Indianapolis.

Services of Shared Dietitian Essential to Small Hospital

Food Supervisor Works Under Her Guidance

A shared dietitian is a necessity in a small hospital to maintain adequate therapeutic diets. Before we had a part-time dietitian, we did not have any sort of planned menus. When we were able to secure the services of a dietitian for two days a week, we provided her with a competent food supervisor who worked under the dietitian's guidance.

After setting up the menus and operation of the kitchen, the dietitian instituted a program of talking to the patients and getting their reactions to the food. She trained the food supervisor to carry on the program. The results have been happier patients and doctors and greater peace of mind for the administrator.—**Velda M. Webster,** Administrator, Fayette Memorial Hospital, Connersville, Ind.



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(Continued from page 7)

Postmaturity Ranked Next to Prematurity

There is evidence that postmaturity ranks second to prematurity as a cause of infant deaths in women delivering their first baby, according to Beatrice E. Tucker, M.D., Northwestern University, Chicago.

A pregnancy of 300 days or longer is considered postmature.

Usually the postmature baby is wrinkled and emaciated rather than big and robust, Dr. Tucker says.

Medical opinion is divided on whether to speed up birth by inducing labor or by cesarean operation after the 43rd week.

Women Inherit Man's Ulcers

Stomach ulcers have increased more than 30 per cent in the last 10 years among women who aspire to "wear the pants," according to John E. Cox, M.D., Memphis.

The modern career woman is a special ulcer candidate as she moves into areas of business once dominated by men.

Artificial Windpipe Provides Airway

An artificial windpipe that can be inserted just below the Adam's apple to provide a temporary life-saving airway to the lungs has been developed by Ralph J. Caparosa, M.D., VA hospital, Pittsburgh.

The gadget consists of a pointed plunger inside a hollow curved metal tube. The gadget is flicked through the neck into the person's own windpipe, and the plunger is withdrawn to uncork the tube.

This allows air to go in and out of the lungs and keeps the patient breathing until a regular windpipe operation can be performed.

High-Protein Diet Suggested for Psoriasis

Victims of psoriasis should go on a low-fat, high-protein diet, stay away from alcohol, and use Lipan in capsule form to facilitate the digestion of fats, according to a report by Frank C. Combes, M.D., New York dermatologist, at the Conference of the Biological Sciences Foundation, Ltd.

Relief obtained by use of this treatment allows the patient to pursue normal activities, the report says.

More than five million people in the United States and Canada now suffer from this ailment.

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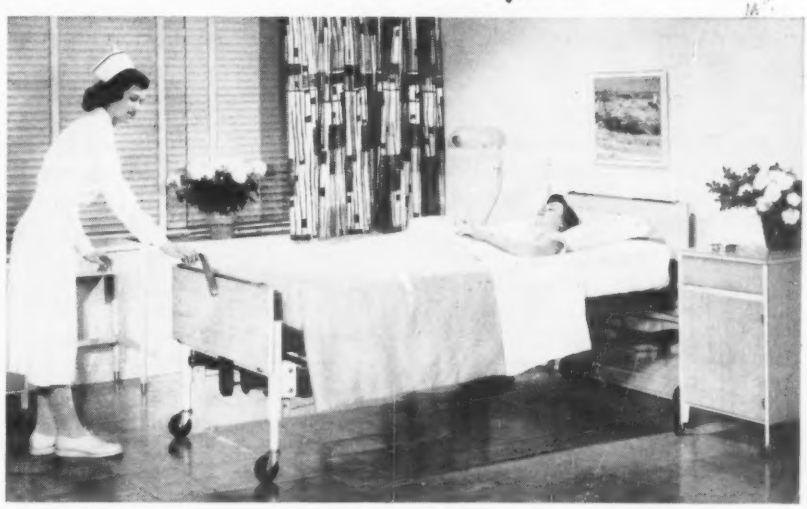

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Complete information on either or both of these high-low beds will be sent on request.

Safety Sides—A New Safety Measure

by Alice L. Price, R. N., M. A.
author of "The Art, Science and Spirit of Nursing"

This Procedure Manual explains in detail how to effectively use Safety Sides to prevent bed falls and to avoid serious injury to patients. Copies for Student Nurses and for the Graduate Nurse Staff will be sent on request.

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Personally Speaking

Above: Newly elected officers pictured at the 24th annual convention of the Mississippi Hospital Association include (l. to r.): S. Earl Grimes, Brookhaven, president; Harry C. Cutler, Kosciusko, president-elect; D. A. Lingle, Laurel, treasurer; B. G. Horton, Ripley, board member; David B. Wilson, M.D., Jackson, board member. Omar Simmons, M.D., Newton, is not shown.

Mrs. Frances Bartlett—has been appointed superintendent, Oneida County Hospital, Malad, Idaho. She succeeds **Mrs. Mildred Atkins.**

Marion L. Bittman—has been appointed administrative director, Benjamin Rose Hospital, Cleveland, O. She will succeed **Josephine Strachan,** who resigned to accept a post with the U.S. Public Health Service, Washington, D.C.

Richard Brooke, Jr.—has been appointed assistant administrator, Riverside Hospital, Jacksonville, Fla.

Fred H. Buchholz, D.D.—is the new full-time chaplain, Lima (O.) Memorial Hospital.

William Burge—has been appointed administrator, Titus County Memorial Hospital, Mount Pleasant, Tex. He formerly was administrator, Battenfield-Jones Hospital Clinic, Synder, Tex.

Cardon C. Clegg—superintendent, Brownsville (Pa.) General Hospital has resigned to become superintendent of Grove City (Pa.) Hospital.

Mrs. Frank Crabb—has accepted the position of superintendent of nurses, Bethesda General Hospital, St. Louis, Mo.

Mary Irene Crawford—has been appointed assistant director of nursing, Presbyterian Hospital, New York City. She will be in charge of nursing care for patients in the Sloane Hospital for Women.

Nicholas J. Daukas, M.D.—has been appointed director of ophthalmology, Hunterdon Medical Center, Flemington, N.J. He succeeds **Donald A. Fonda, M.D.,** who resigned.

Bradford Denson—has been appointed administrator, Leake County Memorial Hospital, Carthage, Miss., succeeding **Henry Boyd.**

B. E. Dillon—has resigned as administrator, Baxter Memorial Hospital, Baxter Springs, Kan., to accept a position in Wichita, Kan.

Joe Erler—has been appointed superintendent, John McDonald Hospital, Monticello, Ia. He succeeds **Mrs. Marie Linder.**

Herbert Frerking, M.D.—has been appointed chief, department of radiology, St. Luke's Hospital, St. Louis, Mo. He succeeds **Oscar C. Zink, M.D.,** who has retired.

John R. Gadd—has been appointed superintendent, Lee Memorial Hospital, Ft. Myers, Fla. He succeeds **R. J. Weinzettel** who resigned to become administrator of the new hospital being built at Waycross, Ga.

Marjorie A. Geesey—has accepted a position as instructor, Capital City School of Nursing, District of Columbia General Hospital, Washington, D.C. She formerly was medical-surgical clinical instructor, Altoona (Pa.) Hospital School of Nursing.

Fred A. J. Geier, M.D.—has been appointed head, department of medicine, Doctor's Hospital, Washington, D.C. He was formerly associate head of the department, and succeeds **Arnold McNitt, M.D.**

Charles Goulet—has been appointed assistant professor of hospital administration, University of Pittsburgh, graduate school of public health. He has been assistant administrator, Cleveland City Hospital since 1953.

Kenneth J. Gross—has been named superintendent, Randolph County Nursing Home, Sparta, Ill. He succeeds **Melvin Lochhead,** who resigned.

Col. Inez Haynes—has been sworn in as chief, Army Nurse Corps, and **Maj. Margaret Harper** is assistant chief.

Ray Hill—has been named administrator, Crippled Children's Hospital, Corpus Christi, Tex.

Charles A. Hix—recently resigned as administrator, Winkler County Memorial Hospital, Kermit, Tex., to become administrator, Lea County Memorial Hospital, Hobbs, N. M.

Lowell Hudson—has resigned as administrator, John Peter Smith Hospital, Fort Worth, Tex. **J. Gus Henderson** has been named acting administrator.

John Hurley—has been installed as president, Nebraska Hospital Association. He is business manager, St. Francis Hospital, Grand Island, Neb.

Lynn Kelly—has resigned as administrator, Maimonides Hospital and Hebrew Nursing Home, San Francisco, Calif.

Paul W. Kempe—has been appointed superintendent, Silver Cross Hospital, Joliet, Ill., to succeed the late **Clinton Smith.**

Charlotte Kern—has joined the staff, Southern Baptist Hospital, New Orleans, La., as teaching dietitian.

Marjorie Lindberg—has been appointed clinical instructor, medical and surgical patient unit, Aultman Hospital, Canton, O.

James E. McCormack—has been appointed assistant vice-president, Columbia-Presbyterian Medical Center, New York City.

Wilbur C. McLin—has been named administrator, Community Hospital, Indianapolis, Ind. The hospital is now under construction.

Jean M. McNeill—has been appointed associate director of nursing education, Aultman Hospital, Canton, O.

E. C. Moeller—administrator, Lutheran Hospital, Ft. Wayne, Ind., has been appointed a member of the Council for licensing and regulating hospitals in Indiana.

Benjamin O. Nelson—has been appointed credit and office manager, Abington (Pa.) Memorial Hospital.

Maybelle H. Osborne—has resigned as public relations director and editor of the hospital publications, St. Mary's Hospital, Waterbury, Conn.

Eugene R. O Brien—has been appointed business manager, Connecticut State Hospital, Middletown, Conn.

Mary Saunders Price—has been named director, Johns Hopkins Hospital School of Nursing, Baltimore, Md.

Rev. William P. Reed—has been appointed Catholic chaplain, Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York City.

John C. Richard—has succeeded **Mrs. Elizabeth Bailey** as administrator, Canonsburg (Pa.) General Hospital.

Norman B. Roberts—assumed the office of business manager, Wichita Falls (Tex.) State Hospital.

John Scott, M.D.—has been named chief of staff, Pikeville (W. Va.) Methodist Hospital. He succeeds **T. I. Doty, M.D.**

Stuart M. Sessoms, M.D.—has assumed the position of assistant director of the clinical center, the combined clinical and laboratory research facility of the National Institutes of Health, Bethesda, Md.

C. K. Shiro—administrator, Deaconess Hospital, Great Falls, Mont., was recently elected president, Montana Hospital Association. Other officers elected were: **Sister Ann Raymond,** administrator, Saint Vincent Hospital, Billings, Mont., president-elect; **George F. Pendergraft,** administrator, Glacier County Memorial Hospital, Cut Bank, Mont., vice-president, and **Sister Theresa of the Cross,** business supervisor, Columbia Hospital, Great Falls, Mont., secretary-treasurer.

Joe Anne Shimonek—has been appointed chief medical record librarian, Indiana University Medical Center Hospitals, Indianapolis, Ind.

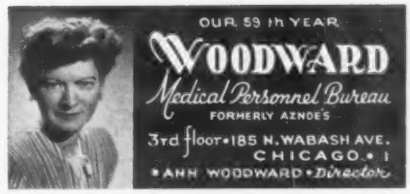
Sister Alfreda—has assumed her new duties as superior, St. Joseph's Hospital, Memphis, Tenn. She succeeds **Sister Narcissa.**

Sister M. Teresita—has assumed the duties of administrator, St. Dominic-Jackson Memorial Hospital, Jackson, Miss. She succeeds **Sister Helen Marie. Sister Ernestine** has been appointed assistant to Sister M. Teresita.

Sister Mary Vincent—assumed the administratorship, St. Joseph's Hospital, Ft. Worth, Tex. She succeeds **Sister Claudine.** Formerly Sister Vincent was administrator, Spohn Hospital, Corpus Christi, Tex.

Sister Virgil—has been transferred from Nazareth Hospital, Mineral Wells, Tex., to Bethania Hospital, Wichita Falls, Tex. **Sister Blanche** succeeds Sister Virgil at Nazareth Hospital.

(Continued on next page)



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POSITIONS OPEN

ADMINISTRATORS: (a) Medical; gen'l vol hosp (JCAH) 500 beds; impor tch'g prog; (d) Gen'l hosp, fairly lge size operated under American auspices; So. America; knowledge of Spanish advantageous. (i) Non-medical, exp'd in bldg program; gen'l vol hosp, 175 beds now expand'g; city, 300,000 on Great Lakes. (m) JCAH, gen, vol hosp, 125 beds; ocean town, Calif.

ADMINISTRATORS (WOMEN): (a) R. N.; also serve as dir of nurs; pref w/ knowl Span; sm gen hosp under American, British, Canadian auspices; sal & full mtce; transp pd; tropic loca. (d) R.N.; female; 100 bd gen hsp affil very lge clin grp; Pac NW. (e) R.N. w/surg exp; new gen hosp 30 bds; lovely sm twn; Iowa.

DIETITIANS: (a) Admin; full resp, new dept; 400 bd gen hosp now u/constr; open fall '56; empl sev mos prior to open date; lovely lge city; SE. (c) Head dept; resp only to admin; JCAH apprv'd 75 bd gen hosp; lovely resort twn 10,000; MW. (d) Chief; expand'g dept; some teach'g of diet ther; vol gen hosp 150 bds; delightful N. England coll twn.

DIRECTOR OF NURSES: (b) Nurs serv incl in-serv trng prog; vol gen hosp 200 bds; to $6000; NW. (c) Nurs serv & ed; apprv'd 200 bd gen hosp; to $6000; twn 10,000; E. (e) Nurs serv & ed; qual ass'ts in both; med sch affil gen hosp 300 bds; 70 students; to $7000; E. (g) Nurs serv & ed; top flight ass'ts in each area; JCAH gen hosp 350 bds; exceptional facil; $6000, full mtce; lge city; Mid E.

EXECUTIVE HOUSEKEEPERS: (a) Supv staff of 75; 400 bd univ hosp; Calif; pref appl from Calif area. (e) Exp'd req; JCAH hosp 120 bds; res twn nr NYC.

FACULTY POSTS: (a) Assoc ed dir; fully apprv'd 500 bd gen hosp; to $5200; Rocky Mtn area. (c) Ed dir; 150 students; very lge gen hosp; outstand'g facil; gd sal, mtce avail; lge univ city; So. (e) Clin instr, med & surg; 400 bd gen hosp affil impor med sch; lge city; So. (f) Psych nurs instr; lge state sch; to $5000; N. England. (g) Nurs arts inst; 400 bd gen hosp; bldg prog just compl; 150 stud, state accred. sch; attrac twn 50,000; Mid E.

POSITIONS WANTED

ADMINISTRATOR: 4 yrs, comptroller, 175 bed gen hosp; since 1952, dir, same hosp; seeks larger hosp as adm, in warm climate; preferably Florida.

ADMINISTRATOR—Woman R.N.; staff, supv exp; 20 yrs, ass't admin, 100 bd child hosp; pref admin appt, 100 bds or less; So. only.

ADMINISTRATOR, (Ass't); 28; MS (hosp adm); 8 yrs, hosp & clinic exper includ'g 2 yrs, hosp adm res & 2 yrs, adm, 40 bed gen hosp; seeks assistanship, lge hosp.

ANESTHETIST—Male; reg'd; excel anes trn'g; nearly 3 yrs anes exp; E & MW, pref lge cities; late 20's.

DIRECTOR OF NURSES—female; 50; B.S.; 20 yrs exp, faculty, ed dir & dir of nurses, various hosps; pref psych hosp, consider gen; East only.

EXECUTIVE HOUSEKEEPER — early 50's; some diet trng; 3 yrs, mgr, lge univ club; 2 yrs, exec hskpr, 200 bd gen hosp; similar posi; MW only.

MEDICAL RECORD LIBRARIAN—elig for reg; 2 yrs, med rec libr, 100 bd gen hosp; seeks similar post, So. only.

PATHOLOGIST: Dipl, (both branches); trn'd Johns Hopkins; 2 yrs, neurologist, impor Army hosps; 2 yrs, instructor, path, univ hosp; 3 yrs, research, path, includ'g 1 yr, research fellow, impor foreign research institute; currently assoc chief path, 1500 bed hosp; seeks chiefship, any locality pref East or West seacoasts; early 30's.

Members of the Columbia University's School of Public Health and Administrative Medicine recently toured the United States Public Health Service Hospital, Staten Island, New York. Pictured above (l. to r.): *Front row:* Clement C. Clay, M.D., associate professor; Magda P. Shorney, M.D., instructor; Joel T. Watson, administrative extern; Edgar N. Duncan, administrative resident; Ralph L. Perkins, administrative officer; Joseph A. Gallegher, M.D., clinical director; John R. Barry, assistant to the administrative officer; Richard E. Sawyer, administrative resident; Jesus M. Rodriguez; Albert Arrisueno. *Second row:* R. June Hagstrom; Oliver E. Deehan; Carlota Rios; Lewis Braun; Leonard R. Piccoli; Thomas H. Bott; Moses A. Walker; Albert Samis; Roy A. Frakes. *Third row:* William D. Thompson; Walter A. Seligman; Raymond J. Lowe; Samuel Davis; Albert R. Sargent; LaVand Syverson; Richard M. Vogel; Harold B. Pine; Bernard Fuss. *Fourth row:* David A. Barrett; John C. Dumas, assistant professor, University of Pittsburgh; John R. Shannon; David A. Peters, M.D.; William R. Blalock; Richard A. Stolnacke; Salvatore S. Bonadonna; Anibal Colon. *Fifth row:* Joseph R. McFerron; Allan B. Caldwell; Francis G. Fosmire; and Gerald J. Clifford.

PERSONALLY SPEAKING Continued

Henry E. Taylor—has assumed the job of administrator, Medical Arts Hospital, Dallas, Tex. He formerly was administrator, Sweetwater (Tex.) Municipal Hospital.

Alice Tomer, R.N.—has joined Grand Valley Hospital, Atoka, Okla., as director of nursing service.

Lester Tuck—has accepted a position as administrator, Jackson County Hospital, Pascagoula, Miss. He formerly was administrator, Felix Long Memorial Hospital, Starkville, Miss.

Fred Wetzel—has been named business manager, St. Joseph Hospital, Aberdeen, Wash.

W. N. Wiggs—has resigned as manager, Tillman County Memorial Hospital, Frederick, Okla.

Elizabeth J. Yost—director of nursing, Akron (O.) Health Department since 1916, has resigned.

Anna Zimmerman—has been appointed associate director of nursing service, Aultman Hospital, Canton, O. She succeeds **Alice Burton.**

VA Appointments

Rhea Carr, R.N.—has been appointed assistant chief, nursing service, Fort Howard, Md. VA hospital. **Elizabeth Hook, R.N.**—has been named assistant chief, nursing education, at the hospital.

Claud E. Carter, M.D.—has been appointed manager, VA hospital, Butler, Pa. He was formerly manager, VA hospital, Fort Bayard, N. M.

Jean Christiansen, R.N.—has been assigned assistant chief, nursing service, Cheyenne, Wy. VA hospital, where she was formerly acting assistant chief.

Alice Clark, R.N.—is now assistant chief, nursing service, Salt Lake City VA hospital.

Peter J. Dulligan Sr., M.D. — 71, former senior surgeon, St. Mary's Hospital, Brooklyn, N. Y., died July 29. Pope Pius XII named him a Knight of St. Gregory two years ago in recognition of his services to hospitals and charities.

William K. Freeman, M.D.—formerly manager, VA hospital, Gulfport, Miss., has been appointed manager, VA hospital, Downey, Ill. He succeeds **Lee G. Sewall, M.D.**

Stewart T. Ginsberg, M.D.—has been named head, psychiatric division, Veterans Administration Psychiatric-Neurology Service, Washington, D. C.

Oliver W. Greer, M.D.—has been appointed manager, VA hospital, Lake City, Fla. He formerly was manager, VA hospital, Newington, Conn. He succeeds **Oma E. Herndon, M.D.** who has been transferred to VA regional office, Atlanta, Ga.

Roland W. Hipsley, M.D.—has been named manager, Lebanon, Pa. VA hospital. He formerly was manager, Minot (N. D.) VA hospital.

George R. Hiskey—has been appointed manager, VA hospital, Cleveland, O. He formerly was assistant manager, VA Center, Wood, Wis.

John C. Phillips—manager, VA hospital, Cleveland, O., has been appointed manager, VA Center, Dayton, O. He succeeds **John I. Spreckelmyer,** transferred to VA central office, Washington, D. C.

Irving Eldridge, M.D.—has been appointed manager, VA hospital, Ft. Bayard, N. M. He succeeds **Claude E. Carter, M.D.**, who was transferred to Butler, Pa.

John G. Hood, M.D.—has been appointed director, VA area medical office, Columbus, O. He formerly was manager, VA hospital, Bronx, N.Y.

Paul M. Ireland, M.D.—has been appointed manager, VA hospital, Ann Arbor, Mich. He was director of surgical service, VA Central office, Washington, D. C.

Lowell C. Like—manager VA hospital, Walla Walla, Wash., has been transferred as manager, San Fernando, Calif., VA hospital.

Charles S. Livingston, M.D.—has been appointed manager, VA hospital, Batavia, N.Y. He formerly was manager, VA hospital, Butler, N. M.

Charles Lucas—former assistant manager, Portland hospital, has been named assistant manager, Vancouver and Portland VA hospitals.

William J. McCarty, M.D.—has been appointed manager, VA hospital, Wilkes-Barre, Pa. He was formerly manager, VA hospital, Vancouver, Wash. He succeeds **M. Herbert Fineberg, M.D.** at Wilkes-Barre.

J. Gordon Spendlove, M.D.—former manager, Portland hospital, will be manager, VA consolidated hospitals at Vancouver and Portland.

Ralph H. Zemer, M.D.—was recently appointed clinical director, Huntington (W. Va.) State Hospital. Dr. Zemer formerly served as assistant superintendent, City Hospital, Apple Creek, O.

Deaths

John W. Abbitt, M.D.—69, chief of surgery, and chief of staff, Maryview Hospital, Portsmouth, Va., died September 26.

Hugh McDowell Beebe, M.D.—72, surgeon and former chief of staff, St. Joseph's Mercy Hospital, Ann Arbor, Mich., died October 3.

Robert H. Bishop, Jr., M.D.—76, former city health commissioner, and director of University Hospitals, Cleveland, O., died September 29. He was formerly president, American College of Hospital Administrators.

Robert B. Cadman, M.D.—59, chief allergist, Chestnut Hill Hospital, Philadelphia, Pa., died September 27.

Albert J. Chesley, M.D.—78, secretary and executive officer, Minnesota Board of Health, died October 17.

Mrs. James S. Collins—60, who was known professionally as **Patricia Drant, M.D.**, died October 3. She was chief of staff in dermatology, Abington Memorial Hospital, Methodist Hospital, and Woman's Hospital, all in Philadelphia, Pa.

Herman P. Davidson, M.D.—62, staff member Presbyterian and Chicago Memorial Hospitals, Chicago, Ill.

Fred W. Fitz, M.D.—53, former chief of heart and circulation clinic, Northwestern University, and former president, medical staff Passavant hospital, Chicago, died October 7.

Noble Sproat Heaney, M.D.—75, retired medical educator and physician, and former president, American Gynecological Society, died September 26 in Los Angeles. He formerly was head, obstetrics and gynecology department, Rush Medical College, Chicago, Ill.

Julius H. Hess, M.D.—79, pediatrician noted for his efforts in saving the lives of premature infants, died November 2 in Los Angeles. He was Professor Emeritus of Pediatrics at the University of Illinois.

Thomas T. Makie, M.D.—60, noted tropical disease specialist, died October 5 in Westport, Conn.

Alfred M. Mamlet, M.D.—59, chief, otolaryngology department, Clara Maas Memorial Hospital, Newark, N. J., died September 7.

Carl R. Moore—62, internationally known authority on the biology of sex, and pioneer in hormone studies died October 16 in Chicago.

Edward J. Moore, M.D.—49, member of the faculty, Jefferson Medical College, Philadelphia, Pa., died September 28.

John Nelson Neill Osburn, M.D.—69, eye specialist and chief eye surgeon, Santa Fe Hospital, Balboa, Calif., died October 11.

Dorothy J. Sivitz, M.D.—33, head, pediatric cardiology clinic, Osteopathic Hospital, Philadelphia, Pa., died October 6.

Charles Solomon, M.D.—59, noted physician in the field of internal medicine and staff member, Jewish Hospital of Brooklyn, N.Y., died September 15.

(continued on next page)

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MEDICAL TECHNOLOGISTS: (a) East. 500 bed hospital. Laboratories all new and modern. Must be A.S.C.P. to $6500. (b) Chief. California. 160 bed hospital near San Francisco. $470. (c) Chief. East. Complete supervision of laboratory. 4 years experience at least. 250 bed hospital. $475. (d) Chief. Middle West. Supervise 2 clinical laboratories under direct supervision of certified pathologist. $500. (e) South. 125 bed hospital. 3 technologists in laboratory. $325. (f) Pacific Northwest. 100 bed general hospital, fully approved. $375 (g) Blood Bank. Middle West. 100 bed hospital in small college town. Can continue work toward degree if desired; $350-$400. (h) East. Blood chemisties and some bacteriology. 200 bed hospital. $300 plus maintenance.

NOTE: We can secure for you the position you want in the hospital field in the locality you prefer. Write for application—a postcard will do. All negotiations strictly confidential.

STATEMENT REQUIRED BY THE ACT OF AUGUST 24, 1923, AS AMENDED BY THE ACTS OF MARCH 3, 1933, AND JULY 2, 1946 (Title 39, United States Code, Section 233) SHOWING THE OWNERSHIP, MANAGEMENT, AND CIRCULATION OF HOSPITAL TOPICS, published monthly at Chicago, Illinois, for October 1, 1955.

The names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Gordon M. Marshall; Editor, Marie Jett; Managing Editor, Lois Smith; Business Manager, Gunhild Moberg; all at 30 W. Washington Street, Chicago, Illinois.

The owner is The Hospital Buyer Company, Incorporated, the capital stock thereof owned by Gordon M. Marshall, Dr. James F. Fleming, George G. Curtis, all of Chicago; and Dr. Brendan Phibbs of Casper, Wyoming.

The known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities are none.

Gunhild Moberg (Business Manager)

Sworn to and subscribed before me this day 30th day of September, 1955.

J. Elkins

(My commission expires December 4, 1958)

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The new Posey "Patient Aid" is another rehabilitation product which encourages self-exercise and is a positive aid to the geriatric. The patient can raise himself without calling for the nurse.
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Gets your patient out of bed . . . useable with both wheelchairs and conventional chairs.

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Standard Model: P-4147, $5.75. Extra-heavy model: P-353. Riveted construction with keylock buckles, $18.75 each. Keeps patient in bed.

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DEATHS Continued

Paul R. Weeks, M.D.—radiologist and staff member, Presbyterian, St. Luke's, and St. Joseph's Hospitals, Denver, Colo., died September 20.

Kenneth B. Turner, M.D.—54, director of cardiology, Presbyterian Hospital, New York City, and associate professor of clinical medicine, College of Physicians and Surgeons, Columbia University, died October 9.

Surgery Scholarship Fund Planned to Honor Dr. Gray

A scholarship fund in memory of Howard K. Gray, M.D., Mayo clinic surgeon who recently drowned, has been announced.

The memorial fund will be used for a traveling scholarship for an outstanding fellow in surgery at Mayo foundation.

National Health Forum To Be Led by Dr. Klumpp

Theodore G. Klumpp, M.D., treasurer, Commission on Chronic Illness, will be chairman of the 1956 National Health Forum, March 21-22, New York city.

The forum will be on chronic illness. It will deal with specific activities under way to improve care of the long-term patient. It will also feature community responsibility for action on chronic illness.

Markle Foundation Continues Medical School Grants

A program of five-year grants for medical school faculty members planning careers in academic medicine will be continued by the John and Mary Markle Foundation, New York City.

The dean of every medical school in this country and Canada was invited to nominate a candidate before December 1.

Psychological Testing For Pre-Med Students

A five-year research program, financed by a grant from the Josiah Macy Jr. Foundation, is developing psychological tests to determine in advance a prospective medical student's emotional stability and the strength of his desire to study medicine.

Preliminary results at the University of Texas Medical Branch indicate success of the program, according to D. Bailey Calvin, dean of students.

CLASSIFIED ADS

OPERATING ROOM NURSES

Immediate appointments. 511-bed newly enlarged and finely equipped hospital. Ten operating rooms now completed. Northeastern Ohio stable "All American City" of 120,000. In center of area of recreational, industrial and educational friendly activities. Living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary $240.00 per month with four merit increases. Paid vacation, sick leave, recognized, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

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Immediate appointments. 511-bed newly enlarged and finely equipped general hospital. Duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units. Northeastern Ohio stable "All American City" of 120,000. In center of area of recreational, industrial, and educational friendly activities. Living costs reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania. Friendly, cooperative work relations and conditions. Progressively advanced personnel policies. Starting salary $240.00 per month with sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

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Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

See you in Boston...

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3rd Annual Conference

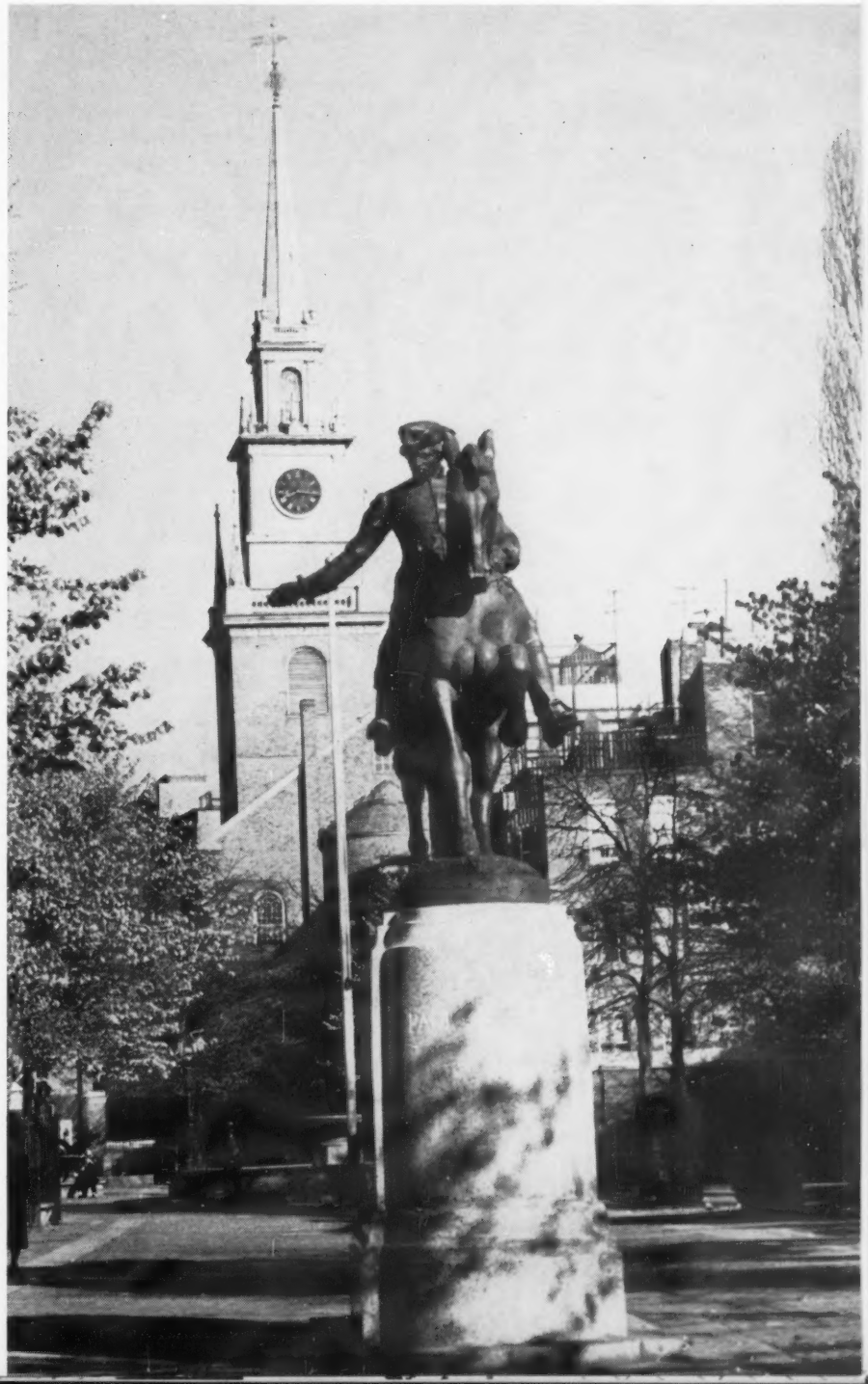
ASSOCIATION OF OPERATING ROOM NURSES

HOTEL STATLER

January 30, 31 and February 1, 1956

IN THIS SPECIAL SECTION:

- What to see and do in Boston
- Where to eat
- Details on:
  - —Scientific exhibits
  - —Delegates' dinner
  - —Bermuda tour
- Latest information on program



At right: Statue of Paul Revere, in Boston's North End. In the background is the spire of the Old North Church. There the lanterns were hung which warned Revere that the Redcoats were coming.

Come to the A.O.R.N. Conference to exchange ideas with operating room nurses from all over the country . . . and to hear experts tell about and demonstrate the latest technics and methods.

While you're there, take time to see some of the picturesque landmarks which recall early American history. Visit one or more of the restaurants recommended by people who ought to know . . . members of the local convention committee.

The third annual conference of the Association of Operating Room Nurses is a meeting you won't want to miss. See you in Boston!

Edith Dee Hall, R.N., Chairman
National Conference Planning Committee

SIGHT-SEEING TOURS

No trip to Boston is complete without a tour of some of the historic spots—like the Old North Church, Faneuil Hall, the Granary Burying Ground, in which are buried John Hancock and Samuel Adams, the Bunker Hill Monument, and Paul Revere's House. You may want to journey to nearby Lexington and Concord . . . or to the site of the Mayflower's landing at Plymouth Rock . . . to Salem, home of the Witch House and the Pioneer Village . . . or to Quincy, in which the home of Presidents John and John Quincy Adams is maintained as it was when occupied.

Sight-seeing tours may be arranged one day in advance. The Gray Line offers, at a special convention rate of $1.75 each for 25 or more persons, two tours: one of historic and modern Boston and one of educational Boston and Cambridge. A third tour—of Cambridge, Lexington, and Concord—is available at the special rate of $3.

Anyone interested in any of the three tours is asked to write to: Miss Muriel M. Dow, R.N., Webster Clinic for Plastic and Reconstructive Surgery, 1101 Beacon St., Brookline 46, Mass., indicating the tour preferred.

POST-CONVENTION TOUR

Reservations for the post-convention tour to Bermuda can be made with the American Express Co. office in any city. The tour will leave Boston by American Airlines at 9 a.m. Friday, February 3, and transfer in New York to Colonial Airlines, arriving in Bermuda at 2:45 p.m. Friday. It will leave Bermuda at 3:45 p.m. Tuesday, February 7, and arrive in New York at 7:45 p.m.

The price of the tour—$143.10 plus $9.90 tax—includes air transportation, hotel accommodations (based on sharing a twin-bedded room with bath), sightseeing, and transfers. It does not include meals, tips, personal items, and Bermuda government tax of $2.85 payable on all round-trip tickets.

A $25 deposit is required at the time the reservation is made. Early reservations are suggested to insure hotel accommodations.

Similar tours to the Bahamas or to Miami may be arranged if enough persons are interested, according to the American Express Co.

ENTERTAINMENT IN TOWN

Conventiongoers who like concerts or the legitimate theater will have a good selection from which to choose. The definite schedule will be announced late in December.

WHERE TO EAT

AMALFI CAFE
10a Westland Ave.
Good Italian food and atmosphere

ATHENS OLYMPIA CAFE
51 Stuart St.
Popular Greek restaurant

BARSANTI RESTAURANT
11 Otis St.
Downtown; Italian-American

BORASCHI CAFE
21 Corning St.
Quaint Italian cafe; good food

CHINA HOUSE
146 Boylston St.
Delightful atmosphere; opposite Common

EDDIE DAVIS' STEAK HOUSE
444 Stuart St.
Specializing in steaks and chops

DINI'S SEA GRILL
94 Tremont St.
Good food at reasonable prices

HAMPSHIRE HOUSE
84 Beacon St.
Distinguished atmosphere and food

THE HI-DA-WAY
3 Boylston Pl.
New England home cooking

JOSEPH'S
279 Dartmouth St.
Dim lights, modern decor

LOCKE-OBER'S
3 Winter Pl.
One of finest sea-food restaurants

MARLIAVE RESTAURANT
11 Bosworth St.
Italian food

PATTEN'S
41 Court St.
Steaks, roast beef, seafood

PROMENADE RESTAURANT
Logan International Airport
Excellent food for travelers

PURCELL'S
10 City Hall Ave.
New England atmosphere

RED COACH GRILL
43 Stanhope St.
Fine beef and seafood

UNION OYSTER HOUSE
143 Stuart St.
In the quaint Market Place

WARMUTH'S PORTSIDE
280 Devonshire St.
Specialty: lobster

JACOB WIRTH'S
31 Stuart St.
Hearty German food; moderate prices

TECHNICAL EXHIBITORS

Abbott Laboratories
Aeroplast Corp.
Aetna Scientific Co.
American Cystoscope Makers, Inc.
American Hospital Supply Corp.
American Safety Razor Corp.
American Sterilizer Co.
Aseptic Thermo Indicator Co.
Austenal Laboratories, Inc.
C. R. Bard, Inc.
Bard-Parker Co., Inc.
Bauer & Black
Rudolph Beaver
Becton, Dickinson & Co.
S. Blickman, Inc.
A. J. Buck & Son
Robert Busse & Co., Inc.
Wilmot Castle Co.
Chesebrough-Pond's, Inc.
Gilbert Hyde Chick Co.
Clay-Adams, Inc.
The Coca-Cola Co.
Codman & Shurtleff, Inc.
Coles Corp.
Conductive Shoe Co.
Connecticut Bandage Mills, Inc.
Crowley & Gardner
Cushman & Denison Mfg. Co.
Cutter Laboratories
Davis & Geck, Inc.
Davol Rubber Co.
J. A. Deknatel & Son, Inc.
Dittmar & Penn Corp.
Doho Chemical Corp.
Duke Laboratories
Eisele & Co.
Eliot Medical Plastics Co.
Ethicon, Inc.
Faultless Rubber Co.
Thomas Fazio Laboratories
The Fengel Corp.
Fenwal Laboratories, Inc.
Gomco Surgical Mfg. Co.
B. F. Goodrich
Gudebrod Bros. Silk Co., Inc.
Harold Supply Corp.
Hoffmann-LaRoche, Inc.
Franklin C. Hollister Co.
Huntington Laboratories, Inc.
Johnson & Johnson
The Lawton Co.
Lehn & Fink Products Corp.
Macalaster Bicknell Parenteral Corp.
MacGregor Instrument Co.
E. F. Mahady Co.
Marsales Co., Inc.
Duncan C. McLintock Co.
Mead Johnson & Co.
Meinecke & Co., Inc.
Miles Laboratories
V. Mueller & Co.
National Electric Instrument Co.
T. J. Noonan Co.
Ohio Chemical & Surgical Equipment Co.
Orthopedic Equipment Co.
Orthopedic Frame Co.
Parke, Davis & Co.
Pharmaseal Laboratories
Phelan Mfg. Co.
George Pilling & Son
The Pioneer Rubber Co.
Propper Mfg. Co., Inc.
Randall Faichney Corp.
Ritter Co., Inc.
Will Ross, Inc.
Sanders & Co.
Dennis R. Scanlan, Inc.
Seamless Rubber Co.
Shampaine Co.
J. Sklar Mfg. Co.
Smith & Underwood
C. M. Sorensen Co., Inc.
E. R. Squibb & Sons
Travenol Laboratories
Vestal, Inc.
Edward Weck & Co., Inc.
Winthrop Laboratories, Inc.
Max Wocher & Son Co.
Zimmer Mfg. Co.

SCIENTIFIC EXHIBITS

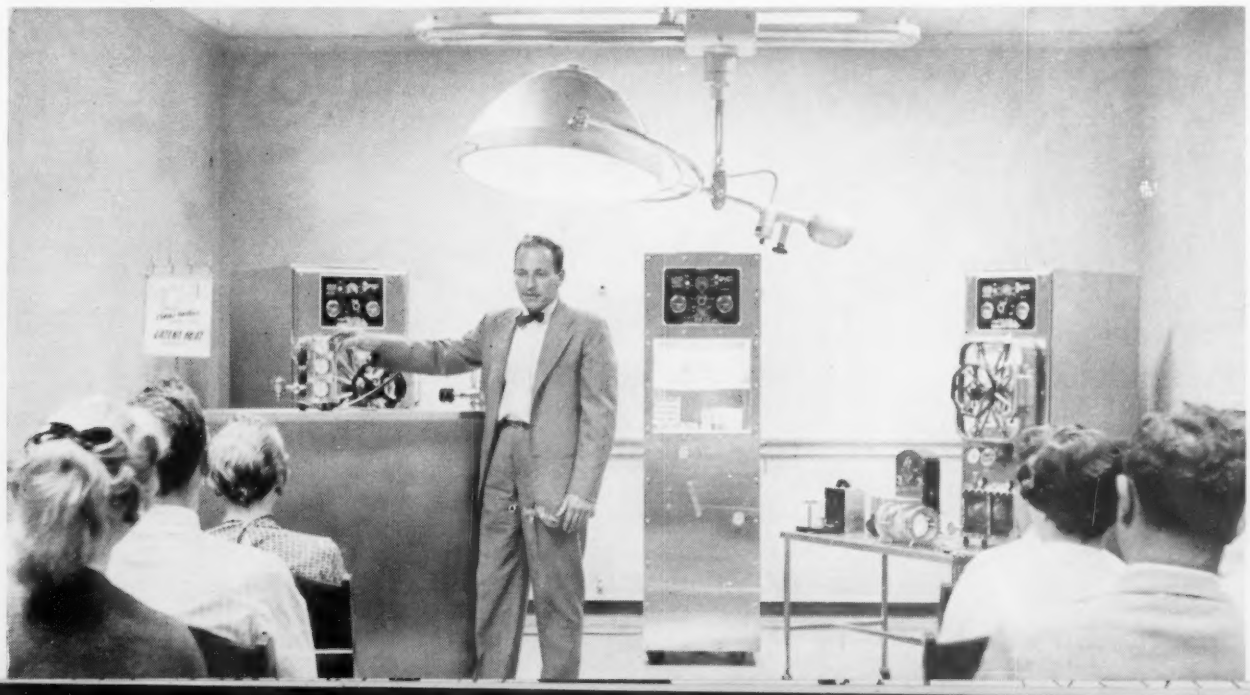
A Reconstructive Surgical Team—Webster Clinic for Plastic and Reconstructive Surgery, Boston
Carcinoma of the Lung—New England Deaconess Hospital, Boston
The Artificial Kidney—Peter Bent Brigham Hospital, Boston
Subdural Hematoma—Donald Matson, M.D., Children's Medical Center, Boston
Plastic Bag Transfusion Technic—Carl W. Walter, M.D., Boston
Sterilization of Solow-Sigmoidoscope (tray)
Kits: Arteriogram, Cardiac Arrest, and Underwater Drainage
Craniostosis (using polyethylene film for repair)
Aneurysm—New England Deaconess Hospital
Autoclaves—James Scott, American Sterilizer Co., Erie, Pa.
Polyps of the Colon—New England Deaconess Hospital
"Tricks of the Trade" (Display of useful, novel, and original ideas from operating room nurses)

DELEGATES' DINNER

The delegates' dinner, which immediately follows the delegates' meeting, will be held at 6 p.m. Sunday, January 29, in Parlor A, Hotel Statler.

Dinner is $5 a plate. Reservations should be sent to: Miss Mary McGovern, 1180 Beacon St., Boston.

Principles of sterilization will be shown in series of demonstrations with mechanical devices, presented in scientific exhibit. Transparent plastic model autoclave is used to show the method of air evacuation from the sterilizer chamber, the latent heat of steam, permeation of the pack, and sterilization of fluids, instruments, and utensils. Demonstration will be under supervision of James Scott (shown below), director, sterilizing division, American Sterilizer Co., Erie, Pa.



HOTELS

1. Avery
2. Beacon Chambers
3. Bellevue
4. Bostonian
5. Bradford
6. Braemore
8. Broadway
9. Canterbury
139. Copley Square
11. Essex
14. Hemenway
15. Huntington
16. Irvington Rooms
17. Kenmore
19. Lenox
20. Lincolnshire
21. Longwood Towers
22. Manger
23. Minerva
24. Parker House
25. Ritz Carlton
26. Shelton
10. Sheraton Plaza
27. Somerset
28. Statler
29. Touraine
30. Vendome
31. YMCA

HISTORIC INTEREST

37. Boston Common
38. Boston Massacre
39. Boston Tea Party
41. Central Burying Ground
42. City Hall
43. Copps Hill Burying Ground
44. Faneuil Hall
45. King's Chapel and Burying Ground
46. Old Granary Burying Ground
47. Old North Church
48. Old State House
49. Old South Meeting House
50. Park Street Church
51. Paul Revere House
52. Public Gardens

TERMINALS

54. Bus
    10 St. James Ave. (Greyhound)
    10 Park Sq. (B. & W., B. & M. T. Co.)
56. 80 Park Sq.
57. Rail
    Huntington Ave. (B. & A. and N.Y.C.R.R.)
58. Trinity Place (B. & A. and N.Y.C.R.R.)
59. North Station (B. & M.R.R.)
60. South Station (N.H., B. & A. and N.Y.C.R.R.)
61. Back Bay (N.H.R.R.)

ASSEMBLY HALLS

66. Arena
67. Boston Garden
68. Boston Opera House
69. Horticultural Hall
70. John Hancock Hall
71. Jordan Hall
72. Mechanics Building
73. N. E. Conservatory of Music
74. N. E. Mutual Hall
75. Symphony Hall

SPORT FIELDS, ETC.

77. Fenway Park

INTERESTING CHURCHES

132. Arlington Street Church
80. Cathedral of the Holy Cross
133. Church of the Advent
134. First Church of Christ, Scientist
135. First Church in Boston
136. St. Anthony Shrine
93. St. Paul's Cathedral
137. St. Thomas More Chapel
95. Temple Israel
96. Tremont Temple
97. Trinity Church

NOTABLE BUILDINGS

78. Cadet Armory
79. Custom House
81. Federal Reserve Bank of Boston
82. Chamber of Commerce
83. Christian Science Publishing Building
84. Frigate Constitution ("Old Ironsides")
85. Hatch Memorial Shell
88. New England Tel. and Tel. Co.
89. Post Office-Federal Building
90. Public Library
91. Quincy Market
94. State House
98 United Shoe Machinery Corp.

SCHOOLS AND COLLEGES

100. Boston University (Charles River Campus)
101. School of Medicine
102. Calvin Coolidge College
103. Emmanuel College
104. Medical School
105. Northeastern University
106. Simmons College
107. Suffolk University
108. Tufts Medical-Dental School
109. Wentworth Institute

MUSEUMS

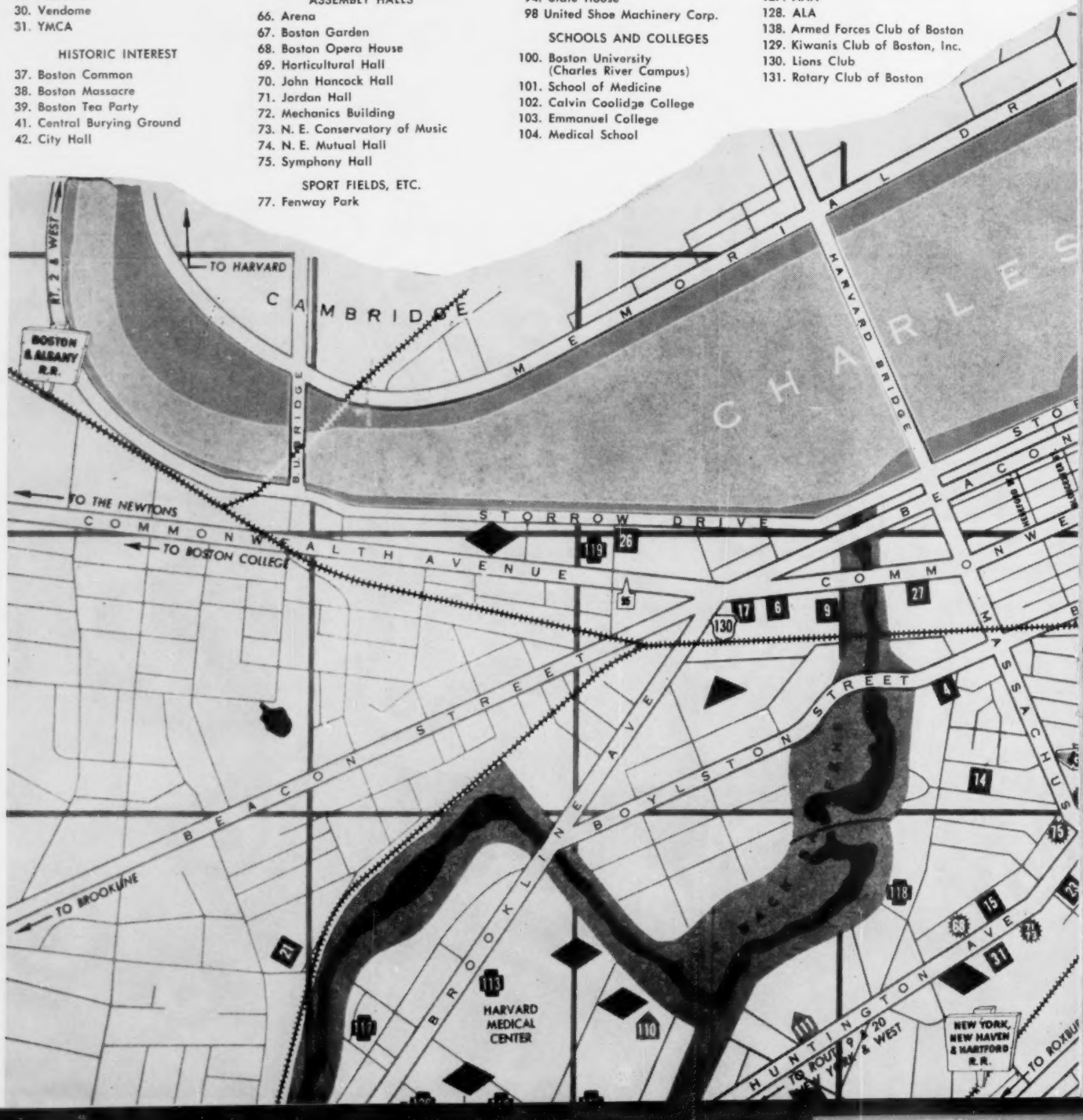
110. Gardner
111. Fine Arts
112. Science & Natural History

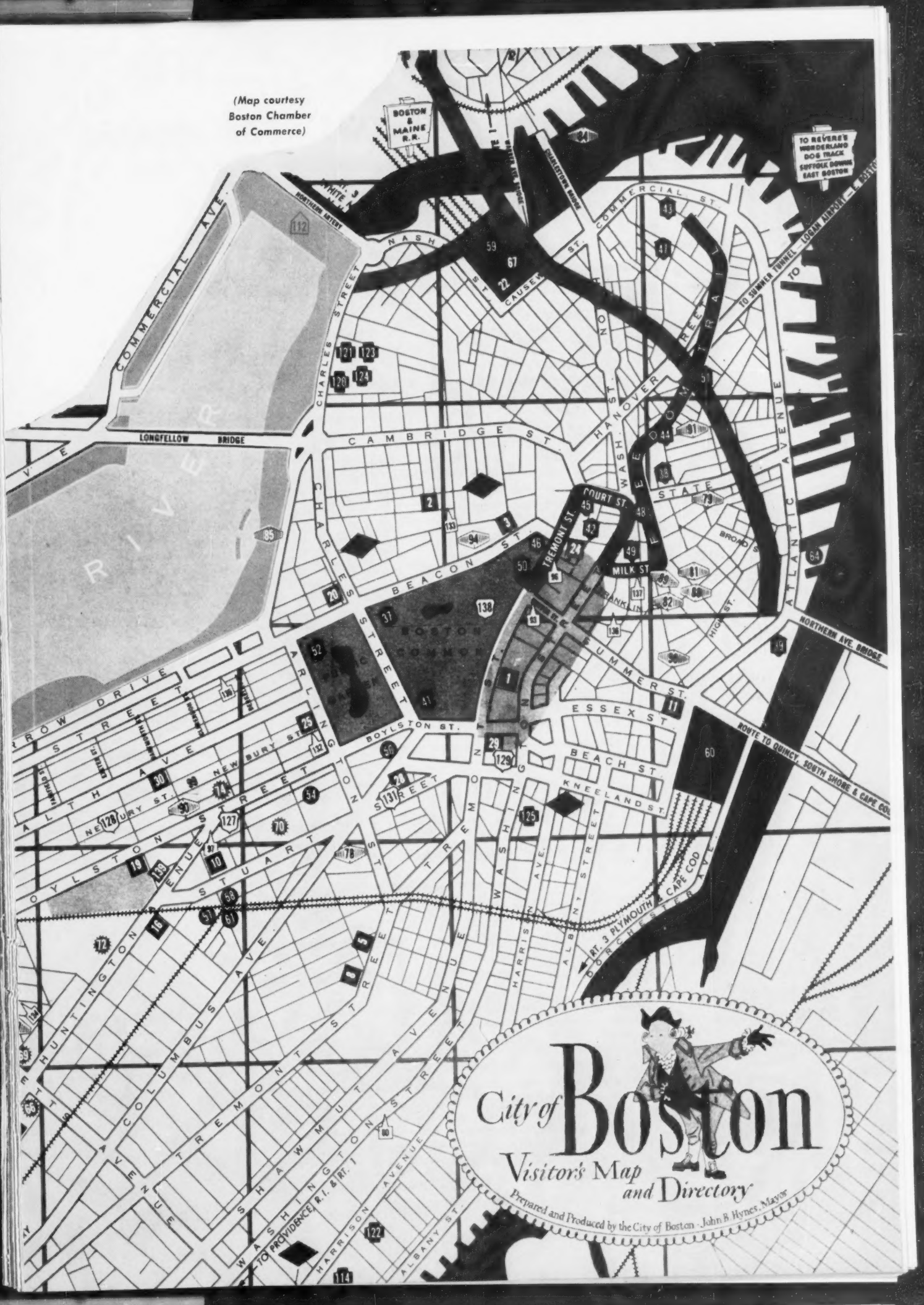
HOSPITALS

113. Beth Israel
114. Boston City
115. Boston-Lying-In
116. Children's Medical Center
117. Deaconess
118. Forsyth Dental Infirmary
119. Lahey Clinic
120. Mass. Eye and Ear Infirmary
121. Mass. General
122. Mass. Memorial
123. Baker Memorial
124. Huntington Memorial
125. New England Medical Center
126. Peter Bent Brigham

SERVICE CLUBS

127. AAA
128. ALA
138. Armed Forces Club of Boston
129. Kiwanis Club of Boston, Inc.
130. Lions Club
131. Rotary Club of Boston




(Map courtesy Boston Chamber of Commerce)
City of Boston
Visitor's Map and Directory
Prepared and Produced by the City of Boston · John B. Hynes, Mayor
BOSTON & MAINE R.R.
TO REVERE'S WONDERLAND DOG TRACK SUFFOLK DOWNS EAST BOSTON
TO SUMNER TUNNEL — LOGAN AIRPORT
COMMERCIAL AVE.
NORTHERN EXPWY.
NASH ST.
CAUSEWAY ST.
COMMERCIAL ST.
CHARLES STREET
LONGFELLOW BRIDGE
CAMBRIDGE ST.
HANOVER ST.
WASHINGTON STREET
ATLANTIC AVENUE
STATE
COURT ST.
TREMONT ST.
MILK ST.
BROAD ST.
FRANKLIN
HIGH ST.
NORTHERN AVE. BRIDGE
BEACON ST.
BOSTON COMMON
SUMMER ST.
ESSEX ST.
BEACH ST.
KNEELAND ST.
BOYLSTON ST.
ARLINGTON STREET
ALTH AVE
NEWBURY ST.
BOYLSTON STREET
STUART
HUNTINGTON AVENUE
COLUMBUS AVE.
TREMONT STREET
WASHINGTON STREET
HARRIS AVE.
ALBANY STREET
HARRISON AVENUE
ALBANY ST.
ROUTE TO QUINCY, SOUTH SHORE & CAPE COD
RT. 3 PLYMOUTH & CAPE COD
DORCHESTER
TO PROVIDENCE, R.I. & RT. 1
SHAWMUT AVE.
RIVER

Third National Conference

ASSOCIATION OF OPERATING ROOM NURSES

Boston, Mass.

January 30, 31 and February 1, 1956

MONDAY, JANUARY 30

Morning Sessions

7:30 a.m. **Registration**

9:00-11:00 ***Georgian Room, Hotel Statler***

Presiding: Elizabeth Cronin, Operating Room Supervisor, Soldier's Home Hospital, Chelsea, Mass., and Past President, Unit I, Massachusetts A.O.R.N.

Panel Discussion: Aseptic Technic

Moderator: Dorothy Dawes, R.N., B.S., M.A., Treasurer, Massachusetts State League for Nursing

Participants:

METHODS OF PRACTICAL APPROACH—Genevieve Young, Ph.D., Instructor in Bacteriology, Boston University

APPLICATION IN THE OPERATING ROOM—Doris Davis, R.N.
Operating Room Supervisor, Worcester (Mass.) Memorial Hospital

APPLICATION IN CENTRAL SUPPLY—Mildred Dodge, Central Supply Supervisor, Boston VA Hospital

ASEPTIC TECHNIC IN THE POSTDOCTORATE PROGRAM—Carl W. Walter, M.D., Surgeon, Peter Bent Brigham Hospital, Boston

Discussion, with audience participation

9:00-11:00 ***Bay State Room, Hotel Statler***

9:00-10:00 Presiding: Kathryn O'Donnell, R.N., Chief Nurse, Overholt Thoracic Clinic, Boston

Aortic Resection with Homograft
(Procedure of securing and preserving graft)
Herbert Adams, M.D., Lahey Clinic, Boston; Consultant, Naval Hospital, Chelsea, Mass.

10:00-11:00 Presiding: Blanche Wallace, R.N., Lahey Clinic, Boston

Surgical Management of Rheumatic Valvular Heart Disease
Wilfred B. Neptune, M.D., Associate at Overholt Thoracic Clinic, Boston, and Thoracic Surgeon, New England Deaconess Hospital, Boston

8:45-11:00 ***Parlors B and C, Hotel Statler***

8:45- 9:15 Presiding: Virginia Davidson, R.N., New England Medical Center

How Can the Surgical Supply Dealer Help You with Your $64 Questions?
Frank Rhatigan, Executive Secretary, American Surgical Trade Association, Chicago

9:30-11:00 Presiding: To be announced

Kidney Transplant
Joseph E. Murray, M.D., David M. Hume, M.D., and John P. Merrill, M.D., Peter Bent Brigham Hospital, Boston

11:00 a.m.-3:00 p.m. **Viewing of Scientific and Technical Exhibits**

Afternoon Session

3:00- 5:00 p.m. **Auditorium, John Hancock Hall**

Presiding: Edith Dee Hall, R.N., New York City, Chairman, National Conference Planning Committee, A.O.R.N., and Mrs. Ethel Balduff, R.N., President, Unit 1, Massachusetts A.O.R.N.

Welcoming Address
Richard T. Viguers, Administrator, New England Center Hospital, and President, New England Hospital Assembly, Boston.

Panel Discussion: Operating Room Nurses Prepare to Meet Community Disaster

Moderator: Mary A. Maher, B.S., M.A., Director, School of Nursing, University of Massachusetts, Amherst, Mass.

Participants:

ADMINISTRATION DURING DISASTER—Charles V. Wynne, Superintendent, Waterbury (Conn.) Hospital

SUPPLIES AND EQUIPMENT—Sister Coronadis, R.N., Assistant Operating Room Supervisor, St. Vincent's Hospital, Worcester, Mass.

BURNS—Albert Murphy, M.D., Boston City Hospital (who helped care for victims of Cocoanut Grove fire in Boston several years ago)

PRACTICAL CONSIDERATION IN HANDLING TRAUMATIC WOUNDS—George R. Dunlap, M.D., Worcester (Mass.) Memorial Hospital

Discussion—with audience participation

TUESDAY, JANUARY 31

Morning Sessions

9:00-11:00 a.m. **Georgian Room, Hotel Statler**

Presiding: Helen Coghlan, R.N., Assistant Director of Nurses in Charge of Operating Room, Massachusetts General Hospital, Boston

Panel Discussion: Foundations of Teamwork

Moderator: Mary V. Schwendeman, R.N., Administrative Supervisor, Presbyterian and Woman's Hospitals, University of Pittsburgh

Participants:

UNDERSTANDING PERSONNEL—J. M. de los Reyes, M.D., Los Angeles, California State Regent, International College of Surgeons

PROGRAM FOR GRADUATE NURSES—Eula L. Phillips, R.N., Operating Room Supervisor, Francis Delafield Hospital, New York City

PROGRAM FOR POSTGRADUATE NURSES—Speaker to be announced

Discussion—with audience participation

9:00-11:00 ***Bay State Room, Hotel Statler***

Presiding: Ann La Vigne, R.N., New England Medical Center Hospital, Boston

Emergencies Arising in the Operating Room*

(Cardiac arrest, tracheotomy, laryngeal spasm, aspiration, blood loss)

John W. Strieder, M.D., Thoracic Surgeon, Massachusetts Memorial Hospital, Boston and Julia Arrowood, M.D., Chief of Anesthesiology, Massachusetts Memorial Hospital, Boston

**Scientific exhibits will supplement these lectures.*

8:30-11:00 ***Parlors A, B, and C, Hotel Statler***

8:30- 9:45 Presiding: Ruth Pendleton, R.N., Director of Operating Rooms, New England Deaconess Hospital, Boston

Explosion Hazards—Lecture and Demonstration

George W. Thomas, M.D., Chief Anesthesiologist, St. Francis Hospital, Pittsburgh, Pa.

10:00-11:00 Presiding: Alice Tremblay, Operating Room Supervisor, Maine General Hospital, Portland, Me.

Surgical Technical Aides in Action

Moderator: Frances Ginsberg, R.N., Operating Room Consultant, Boston

NURSE TRAINEE—Mrs. Linda K. Alden, R.N., Operating Room Supervisor, Monmouth Memorial Hospital, Long Branch, N. J.

AIDE TRAINEE—Mrs. Barbara Shepard, Surgical Technical Aide, Cooley Dickinson Hospital, Northampton, Mass.

NURSE UTILIZING AIDES—Katherine Vachula, R.N., Operating Room Supervisor, Cooley Dickinson Hospital, Northampton, Mass.

11:00 a.m.-3:00 p.m. Viewing of Scientific and Technical Exhibits

Afternoon Session

3:00- 5:00 p.m. **Auditorium, John Hancock Hall**

Presiding: Edith Dee Hall, R.N., Chairman, National Conference Planning Committee, A.O.R.N.
Moderator: Sister Mary Justine, R.N., Nursing Service, Carney Hospital, Boston

New Horizons—Expanding Opportunities for Operating Room Nurses in the Distribution of Medical Care

Example: A Reconstructive Surgical Team

Presented by the Webster Clinic for Plastic and Reconstructive Surgery, Boston. Team members:

Richard C. Webster, M.D., Director

Richard J. Coffey, M.D.

Muriel Dow, R.N.

Virginia Rainville, R.N.

Francis G. Fuery, Administrative Associate

James A. Russell, Research and Education

Team functions in over 50 hospitals in the Boston area. Program will include: Films of hospital surgery, taken by nurses; slides showing surgical patients; use of micro-filmer, showing indexing of cases; display of large map showing territory and hospitals covered by team, and demonstration showing how team functions. There will be a demonstration with a live model to show full-figure posterior cast for burns being put on by nurses.

WEDNESDAY, FEBRUARY 1

Morning Sessions

9:00-11:00 — **Georgian Room, Hotel Statler**

Presiding: Janie Krause, R.N., University of Minnesota Hospitals, Minneapolis, Minn., Co-chairman, National Conference Planning Committee, A.O.R.N.

Panel Discussion: Clinical Instruction Programs for Student Nurses

Moderator: Marie Farrell, Ph.D., Acting Dean, Boston University School of Nursing, Boston

Participants:

Mary V. Schwendeman, R.N., Administrative Supervisor, Presbyterian and Woman's Hospitals, University of Pittsburgh, Pittsburgh, Pa.

Sister Justine, Operating Room Supervisor, Providence Hospital, Washington, D.C.

Jean Dodds, Operating Room Supervisor, Toronto (Ont.) General Hospital

Discussion—with audience participation

9:00-10:00 — ***Bay State Room, Hotel Statler***

Presiding: Margaret Burns, Operating Room Supervisor, New England Deaconess Hospital, Boston

Use of Hypnosis in Medicine, with a Demonstration

Naif Simon, M.D., Chief Anesthesiologist and Director, School of Anesthesia for Nurses, Quincy (Mass.) City Hospital

10:00-11:00 — Presiding: Mrs. Esther Katz, R.N., Operating Room Supervisor, Brooks Hospital, Brookline, Mass.

Planning and Managing the Recovery Room

Eugene Rosenfeld, M.D., Administrative Director, Long Island Jewish Hospital, New Hyde Park, N.Y.

Discussion—with audience participation

9:00-11:00 — ***Parlors A, B, and C, Hotel Statler***

9:00-10:00 — Presiding: Mrs. Doris Walk, R.N., St. Louis, Co-chairman, National Conference Planning Committee, A.O.R.N.

Ionizing Radiation in Sterilization: Technics and Development of New Methods

F. L. Foster, Jr., Sales Manager, High Voltage Engineering Corp., Cambridge, Mass.

10:00-11:00 — Presiding: Rita Doyle, Operating Room Supervisor, Whidden Memorial Hospital, Everett, Mass.

Orthopedic Surgery

Speaker to be announced

11:00 a.m.-3:00 p.m. — **Viewing of Scientific and Technical Exhibits**

Afternoon Session

3:00- 5:00 p.m. — **Auditorium, John Hancock Hall**

Presiding: Edith Dee Hall, R.N., New York City, Chairman, National Conference Planning Committee, A.O.R.N.

Problem Clinic*

Moderator: To be announced

Participants:

ADMINISTRATOR—George W. Graham, M.D., Director, Ellis Hospital, Schenectady, N.Y.

OPERATING ROOM SUPERVISOR—Ruth Pendleton, R.N., Director of Operating Rooms, New England Deaconess Hospital, Boston

PRODUCTS REPRESENTATIVE—A. B. Wiley, Sales Manager, Eastern Hospital Division, Johnson & Johnson, Newark, N. J.

HOSPITAL CONSULTANT— J. J. Egan, Sales Manager, Hospital Division, S. Blickman, Inc., Weehawken, N. J.

MAINTENANCE ENGINEER—George Alcock, Mt. Auburn Hospital, Cambridge, Mass.

SURGEON—To be announced

PURCHASING AGENT—Joseph Keyes, Purchasing Agent, Englewood (N.J.) Hospital

**Bring your $64,000 questions to this session, and direct them to any panel member*

Closing Address

J. M. de los Reyes, M.D., Los Angeles, California State Regent, International College of Surgeons

THURSDAY, FEBRUARY 2

"A.O.R.N. Hospital Day"

Tentative plans have been made for conventiongoers to visit the Beth Israel Hospital, Peter Bent Brigham Hospital, Massachusetts General Hospital, Boston City Hospital, and the New England Deaconess Hospital. Other hospitals probably will be added to the list.

Approximately 335 visitors can be accommodated at the hospitals which have given tentative permission. Tours of recovery rooms and central supply rooms are being planned for groups of 10 to 15 nurses by the Peter Bent Brigham, New England Deaconess, and Beth Israel Hospitals.

Chairman of the hospital clinics program is Ruth E. Pendleton, R.N., director of operating rooms, New England Deaconess Hospital.

TRADE TOPICS...

Elizabeth L. Hazen, M.D., and Rachel Brown, M.D., division of laboratories and research, New York State Department of Health, Albany, N. Y., have been awarded the $5,000 Squibb award in chemotherapy in recognition of their discovery of nystatin, the antifungal antibiotic. The drug was obtained by the doctors from a microorganism found in soil from a Virginia dairy farm. The drug was made available to doctors last year under the name of Mycostatin by E. R. Squibb & Sons. It is also being supplied to doctors in combination with tetracycline, under the name Mysteclin.

Christmas Spirit Ad In Fortune Magazine

Hoping to co-ordinate Christmas giving with the need of hospitals and medical schools for financial support, American Hospital Supply Corp. sponsored a page advertisement in the November issue of *Fortune*.

The ad suggested that business and industrial leaders send Christmas contributions to hospitals and medical schools in their communities in lieu of presents to customers and clients.

Johnson & Johnson To Build New Plant

A new surgical dressing and baby products plant will be built by Johnson & Johnson on a 275-acre site five miles southwest of downtown New Brunswick, N. J.

The first occupancy is scheduled for next summer.

The total area of the plant will be about 600,000 square feet.

Winthrop-Stearns, Inc. Now Winthrop Laboratories

The corporate name of Winthrop-Stearns, Inc., has been changed to Winthrop Laboratories, Inc.

The company was established in 1919 under the name of Winthrop Chemical Co., Inc. It consolidated in 1935 with H. A. Metz Laboratories. In 1942, Alba Pharmaceutical Co. was merged with Winthrop and, in 1947, Winthrop-Stearns, Inc. was organized following the purchase of Frederick Stearns & Co.

Medical Coordinator Named At Parke, Davis & Co.

George M. Shadle, M.D., has been appointed medical coordinator, sales department, Parke, Davis & Co.

He has been with the pharmaceutical firm since July, 1952, as a member of the clinical investigation staff in Pittsburgh.

F. Rosengarten Dies

Frederic Rosengarten, retired chairman of the board, Merck & Co., died October 28. He was 78 years old.

Permacel Tape Corporation Appoints District Manager

Charles F. Euler has been appointed Boston district manager, Permacel Tape Corp. He joined Permacel Tape in 1947 after many years with the Glen L. Martin Co.

Merrell Company Adds New Man

Herbert P. Nack has joined the William S. Merrell Co. as assistant director of marketing. He will direct Merrell's hospital sales.

Mr. Nack formerly was administrative vice-president, T. B. Roerig.

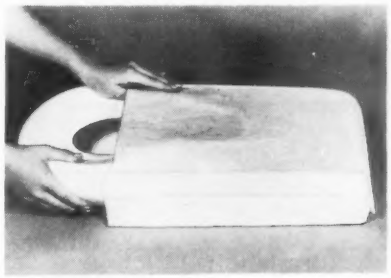
Pfizer Opens Antibiotic Plant in England

Charles Pfizer & Co., Inc. recently opened a new antibiotic plant in Sandwich, England. The plant is geared to the production of broad-spectrum antibiotics, including terramycin.

Universal Foods Names V.-P.

J. A. Reivitz has been named vice-president, Universal Foods Corp. in charge of institutional sales.

(Continued on next page)



DISPOSABLE

SAKIT

Disposable flush away tissue paper bed pan bag. They are savers of time and linen.

3000 - $9.50M; 50,000 - $8.30M
15000 - $8.90M; 100,000 - $7.70M

DISPOSABLE

MASKS

Pleated—no strings to tie—much finer pores than gauze — give greater protection. Made of boilable wet strength stock.

1M $17.50; 5M $16.25M; 10M $15.50M

Samples available from Dept. T.

ROBERT BUSSE & CO., INC.

64 EAST 8th ST. N. Y. 3, GR. 5-8783

Sharp & Dohme Research Grants

Grants by Sharp & Dohme to hospitals, colleges, universities, and institutions for research and clinical studies have totaled $92,550 since August 1, 1954.

Medical division grants to support clinical studies accounted for $38,550 of the total.

Baxter Laboratories Appoints Hetterick

Raymond D. Hetterick has been named vice-president in charge of sales, Baxter Laboratories.

Mr. Hetterick was formerly executive vice-president, Harrower Laboratories.

Fenwal Names Sales Manager, Consultant

Robert A. Schultheiss is the new general sales manager, Fenwal Laboratories, Inc. Previously he was plant engineer and sales promotion manager for the Robbins Co.

John G. Gibson II, M.D., has been employed by Fenwal as research consultant. He is a staff member, department of medicine, Peter Bent Brigham Hospital, Boston, and Harvard Medical School.

American Hospital Supply Names Division Assistants

Appointment of two new assistant division managers has been announced by the American Hospital Supply Corp.

James S. Kennedy, Jr., former manager, contract department, New York division, is now assistant manager of that division.

James S. Lucado, who has been office manager, Dallas division, has been promoted to assistant division manager.

Medical Repair Service Now Open in Chicago

George Liss, formerly chief serviceman for McIntosh Electrical Corp. has opened a repair service on all medical equipment at 3327 West Pierce Avenue, Chicago.

Ethicon Gives $50,000 For Film Library

A gift of $50,000 for the establishment of a medical film library has been made to the American College of Surgeons by Ethicon, Inc.

The college is to use the money as it sees fit, Richard B. Sellars, Ethicon president, said.

Announcement of the gift was made at the 41st annual clinical congress of the organization, held recently in Chicago.

Medical Film Library Gift Given to College of Surgeons

A gift of $50,000 for the establishment of a medical film library has been made to the American College of Surgeons, by Ethicon, Inc.

"The American College of Surgeons was the first surgical organization to recognize the importance of motion pictures as a teaching tool both in medical schools and at medical meetings," H. Prather Saunder, M.D., associate director of the college said.

Overseas Service Corp. Appoints Schoner

Burton M. Schoner has been appointed sales representative, Overseas Service Corp., hospital equipment division. He will work out of the Washington, D.C. office, according to Robert C. Davis, division manager.

New Sales Manager At Austenal Surgical

John H. Begert is the new sales manager, surgical division, Austenal Labs, Inc.

He formerly was with Pierre Mercier Co. of Montreal in the capacity of sales manager.

New Board Chairman For Becton, Dickinson

Max Robin has been elected chairman of the board of directors, Becton, Dickinson and Co. He succeeds the late M. W. Becton, a co-founder of the company.

Promotions Announced At Wyeth Laboratories

Three members of Wyeth Laboratories sales staff have been promoted to new positions within the organization.

Lee J. Hymel, Chicago division manager since 1949, has been named assistant sales manager. Donald E. Gilliland succeeds him as division manager, Chicago territory. Eli E. Main moves up as division manager, Cleveland sales area.

Sklar Executive Dies

Victor W. Filler, an executive of J. Sklar Manufacturing Co., died October 15, in New York City. He was 62 years of age.

Kimble Glass Company Adds New Sales Manager

Walter D. Plummer has been named sales promotion manager, Kimble Glass Co. Kimble is a subsidiary of Owen-Illinois Glass Co.

Mr. Plummer succeeds Harlan Hobbs who was promoted to vice-president of Glasco Products Co., another subsidiary of Owens-Illinois.

Hospital Sales Manager For Lederle Laboratories

Edward M. Blake has been named manager, hospital sales, Lederle Laboratories division, American Cyanamid Co.

Formerly Mr. Blake had been sales manager, Los Angeles district, West coast region.

Blomquist Joins American's Export Promotion Staff

George Blomquist has joined the New York division staff, American Hospital Supply Export Corp.

He will assist John Willman, vice-president, in sales promotion work for the new 845-bed military hospital that American is equipping in Lima, Peru.

Amino Product Division Changes Its Name

Ac'cent International is the new name of the Amino Products Division, International Minerals & Chemical Corp.

Ac'cent is made in San Jose, Calif. Expanded production facilities by the division in 1953 and 1954 have increased the supply of Ac'cent to meet the consumer demand.

Pictured at the ceremony are (l. to r.): J. Roscoe Miller, M.D., president of Northwestern University; Ray E. Brown, Chicago, AHA president; Rt. Rev. Msgr. John W. Barrett, director of Catholic hospitals, Archdiocese of Chicago; Edwin L. Crosby, M.D., director of the AHA, and Frank Bradley, M.D., immediate past president, AHA.

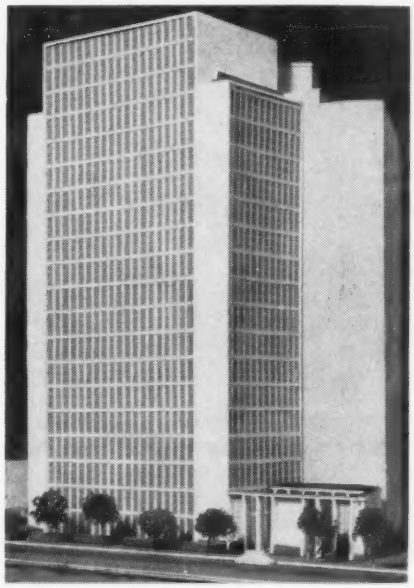
AHA Breaks Ground for New Building

• A ground-breaking ceremony for the new $4,850,000 AHA building was held November 9. The building, as pictured in the architect's model below, will be of light colored glazed brick with prefabricated window wall construction with aluminum facings. It will be built at Pearson Street and Lake Shore Drive on a site made available by Northwestern University.

The property fronts 71 feet on Lake Shore Drive, and has a depth of 325 feet. It is located on the edge of the Northwestern Medical Center.

The building is expected to be completed by June, 1957. It will house the AHA as well as a number of allied groups. Schmidt, Garden & Erikson are the architects for the building.

Principal speakers at the ground breaking ceremony were: Ray E. Brown, president of the A.H.A., J. Roscoe Miller, M.D., president of Northwestern University, and Mayor Richard J. Daley of Chicago.



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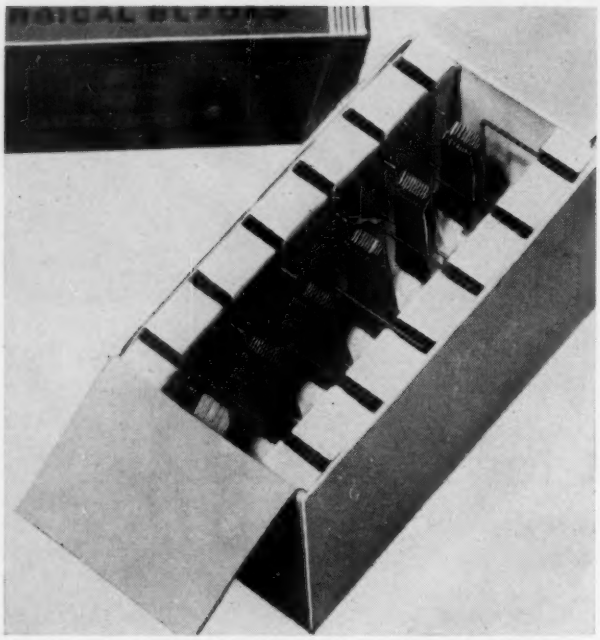
BUYER'S GUIDE

For further information on any of the products, please check the Buyer's Guide number on the reply card facing page 62.

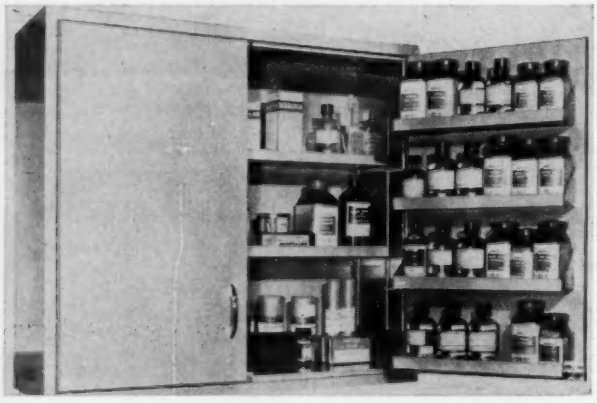
Nina Marie Stein
Buyer's Guide Editor

300. Surgical blades



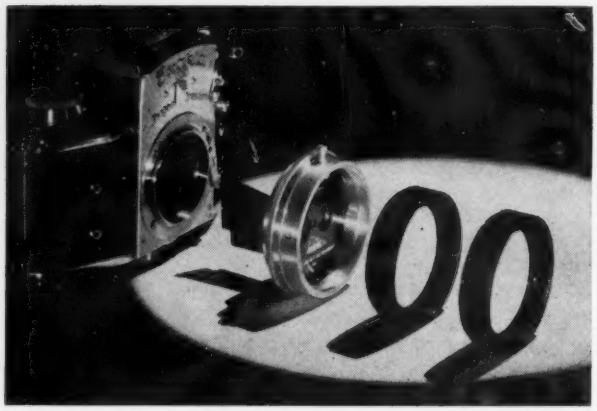
Clip-Sharps is a new convenient method for packing surgical blades. It eliminates the need for handling individually wrapped blades, the manufacturer says. Each box contains one gross of ASR surgical blades in units of 24 unwrapped blades per clip. The required number of blades can be removed easily from the clip and placed onto a rack arm, which then is inserted into sterilizing solution. American Safety Razor Corp.

301. Chemical storage cabinet



Steel cabinet holds all the requirements for average blood chemistry, bacteriology, or histology department. The seven special door trays give every bottle or box a front position. No need to reach over or around to find supplies. American Hospital Supply Corp.

302. Three-dimensional close-ups



Kin-Dar Hypo-Stereo attachment makes three-dimensional photographic close-ups of objects from 12" to within 3" from the lens possible. Manufacturer states attachment expected to find greatest acceptance in medical fields where extreme close-up photography is necessary. Using regular 35mm. color film, the attachment produces two matching transparencies, each four perforations wide, which are then mounted for viewing in stereo viewers. Kin-Dar Corp.

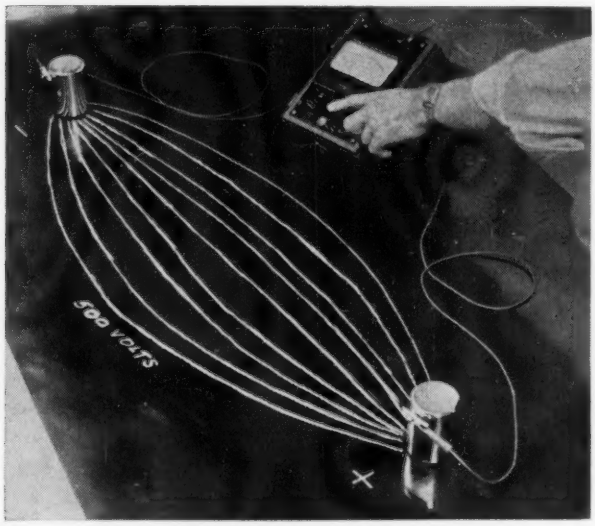
303. Remote control TV unit

Unit features individual speaker so patients can watch TV while others sleep. Lightweight plastic box unit has all the dials of the TV set, including on-off volume, fine tuning, brightener, and channel changer. It allows complete operation from as far away as 20'. Shut-in patients can switch channels without calling for help. Sentinel Radio Corp.

304. Nylon elastic stocking

The first 51-gauge nylon elastic stockings have been developed. Stockings are full-footed and full-fashioned, and give complete support to the leg, according to the manufacturer. Pressure exerted by stocking is greatest at ankle, and diminishes gradually up the leg in accordance with medical requirements. Bauer & Black.

305. Conductive waxes



VC-2C conductive wax is a clear wax for use on all conductive flooring. H-22 is a black wax designed for static-conductive linoleum, rubber, and other conductive floors which are black. Both waxes produce durable, water-resistant surface that can be polished to high luster, according to manufacturer. Tests prove that they retain conductivity for long period of time. Waxes have Underwriters' Laboratories approval. Huntington Laboratories.

306. Serving trays

Toteline serving trays available in burgundy, cream lettuce, cashmere blue, and eight other standard colors. Trays come in six standard sizes, and match plastic dinnerware. Manufacturer states that trays will not warp, dent, or rot. They are lightweight and easily cleaned because of smooth nonporous surface. Molded Fiber Glass Tray Co.

307. Bed commode

Lightweight, all-aluminum Komfort Bed-High Commode is mobile and so designed that patient needs little assistance. Commode can be attached or detached in matter of seconds from bracket that fits any hospital bed. When attached it is impossible for it to topple, according to manufacturer. Commode has foot rest, back rest, and arm rest to add to patient's comfort and safety. For attendant's convenience there is a container molded to fit seat perfectly, and placed in seat from above. Will-Mark Co.

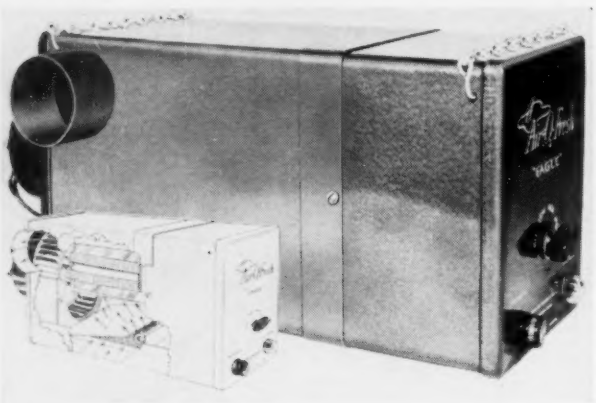
BUYER'S GUIDE

Continued

308. Moist towelette

Wash-'N-Dri, a soft strong tissue that unfolds to a 8½" x 6" size, is ready for instant use, already moistened with fragrant cleansing lotions. Towelette comes sealed in tiny, wafer-thin foil envelope. Makes attractive "conversation piece" for visitors to present to patients. Gift shops throughout the country have found Wash-'N-Dri to be a handy item to stock, according to manufacturer. Each packet has moisture equivalent to one quart of water. R. R. Williams, Inc.

309. Forced air ozonator

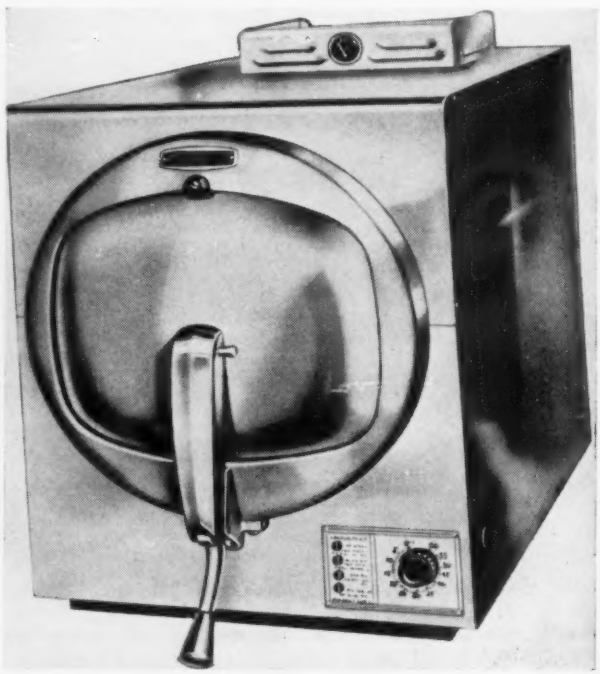


Air-03-Fresh Eagle anti-humidity ozonator produces necessary concentrations of ozone for air deodorization and preservation of meats and foods. Manufacturer reports ozone's ability to: inhibit mold, mildew, and bacteria on meats, foodstuffs, packages, and cooler walls; preserve soft fruits and fresh berries; retard ripening of vegetables; inhibit sprouting of potatoes and onions; eliminate waste slickness on pork and prevent tainting and transfer of food odors. Melco Sales, Inc.

310. Aluminum chair

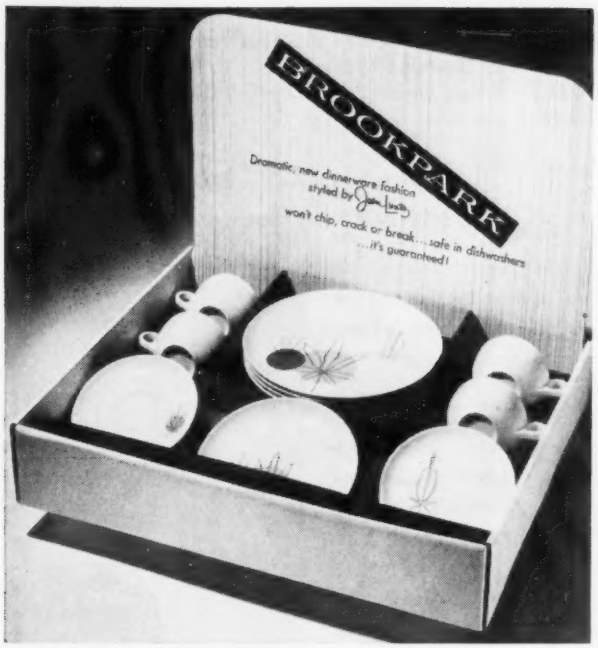
Aluminum straight chair with flared, rubber bumper-equipped legs is designed for faster, easier, safer stacking. Chairs can be nested in single stack as pictured above. Inset shows rubber bumper which protects legs from scratches and other damage. Ohio Chair Co.

311. Compact sterilizer



Direct steam time-controlled Hi-Speed compact sterilizer to provide rapid sterilizing temperatures up to 250° F. within a few minutes. Inner door feature makes it impossible to open sterilizer while steam pressure remains in sterilizing chamber. Aetna Scientific Co.

312. Plastic pattern



Pattern has been brought to plastic dinnerware. Fantasy, the new leaf and circle motif, comes in turquoise and yellow on a white ground or brown and gold on white. Pictured above is Champagne pattern, with an airy tracing of elliptical bubbles, supplied in tones of pink on white. International Molded Plastics, Inc.

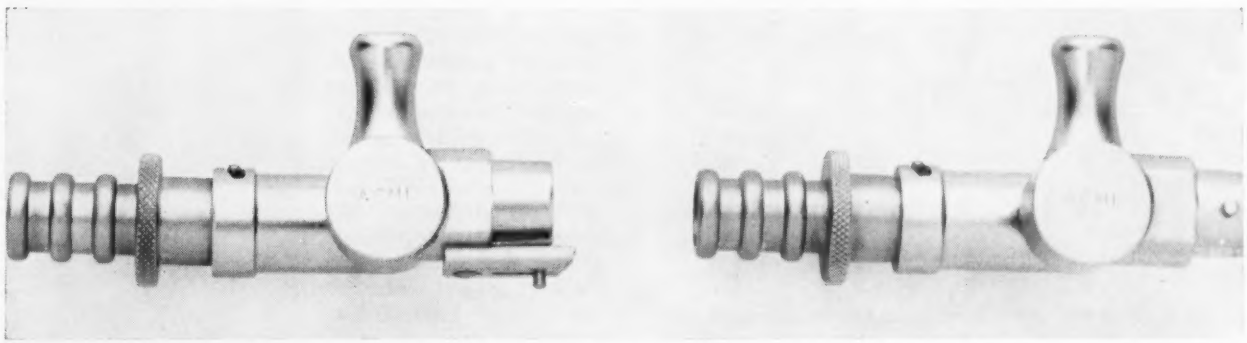
313. Food cost calculator

A dial that determines the cost per serving of fruits, vegetables, and juices, also the size per serving, the number of servings to a tin, and the number of tins needed per 100 servings. Physicians' Record Co.

314. Alesen T-tube

Disintegrating Alesen T-tube reduces hazard of duodenal stump disruption and prevents encroachment upon gastrojejunal lumen due to kinks, angulations, or postoperative edema, according to the manufacturer. Tube is discharged in five to seven days postoperatively when internal splinting is no longer needed. Seal-In Labs, Inc.

315. Burns valves



Valves are available for emptying Ellik, Hutch, McCarthy, or Toomey type evacuator without detaching evacuator from resectoscope or cystoscope sheath. Distal end of valve contains standard cord connection and cone for attachment to resectoscope sheath. Evacuator attached to proximal end by means of connector. American Cystoscope Makers, Inc.

316. Electronic call system

Features of the system include: special lavatory emergency button that flashes a patient's call for help throughout all nurses' duty stations, optional "staff director" system that locates and pages persons, and reduced installation costs with all stations adapted to standard electrical boxes, according to the manufacturer. Dukane Corp.

317. Dry powder aerosol

Spot control of small fires fed by flammable liquids, or caused by electrical short-circuits, is offered in a push-button aerosol package that uses dry powder as fire-killing agent. Eliminating toxicity associated with carbon tetrachloride, product uses specially treated bicarbonate of soda to put out class B and C fires. Because bicarbonate of soda is non-toxic, food doused with chemical needs only to be washed off to remain edible. Safe, Inc.

337. Surgical dissecting scissors

Scissors feature blades with new wedge shape in plane of shanks to give greater utility in every phase of tissue dissection, manufacturer says. It has thinner tips for improved visibility when cutting space is limited. Scissors has rounded tips for probing. Clay-Adams Co.

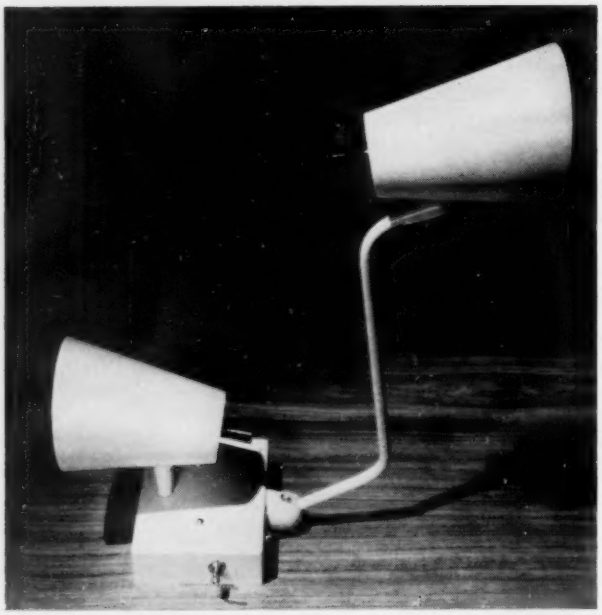
318. Professional mitten

Mitten can be autoclaved and is designed to protect both the wearer and the instruments in autoclaving. Pel-Mitt is made of strong, unbleached terricord, backed by fleecy lined canvas. It fits all sizes, reaches to the wrist. Pelton & Crane.

BUYER'S GUIDE

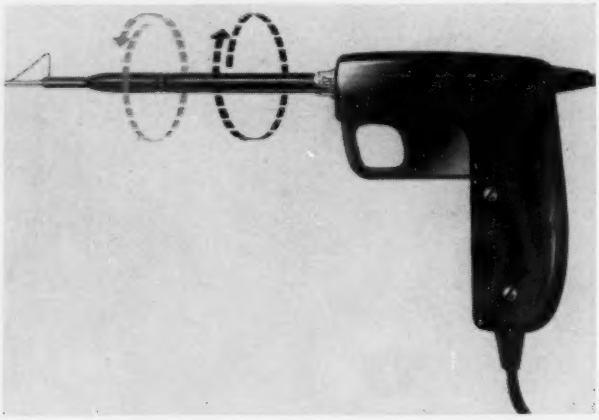
Continued

319. Hospital light



All lighting facilities are combined into one unit. Light can be used for reading, eating, examination or treatment, resting or sleeping, according to the manufacturer. Swivels allow 360° rotation of shade, retains constant tension, and operates smoothly at all times. Lights are supplied in standard oyster colors. Unit may be fitted with four shades; metal cone, fabriglas, fabriglas with embedded maple leaf, or white fabriglas with embedded rattan. Prescolite Mfg. Co.

320. Surgical pistol

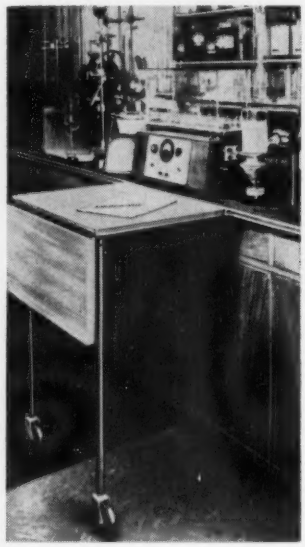


Surgical pistol for cervix conization can be operated with one hand, leaving the other free for other instrumentation. One pull of trigger gives a complete 360° cone. Stability offered by grip results in smooth uniform excisions. Welch-Allyn lamps are built into front of unit, giving perfectly illuminated field. Birtcher Corp.

321. Water heater

Monel Sanimaster storage gas water heat simultaneously provides hot water at two different temperatures from a single tank. Produces water at 180° F. for sanitizing purposes from one outlet, and water at 140° F. for general use from the other. Crane Co.

322. Lab bench

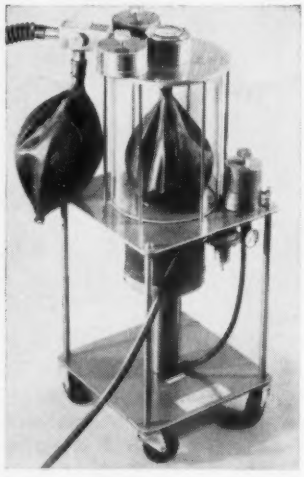


Mobile bench unit gives five square feet of extra working space right at the bench. It rolls along bench on guide rail to give extra space when needed. Bench is level with permanent bench, yet can instantaneously be rolled along to a new position; can be used on wood, metal or stone top tables. Rolla-Bench has solid teak top and tubular steel legs. Palo Labs.

323. Garbage cabinet

Can-tainer is a durable, 20-gauge cold-rolled steel cabinet. Cabinet is built with self-sealing lid, through which garbage is deposited, and a large hinged door from which filled garbage can be removed. Hollow base may be filled with sand so cans won't upset. Can-tainer is over 33" in height and 21" wide. Neatway Products, Inc.

324. Jefferson ventilator

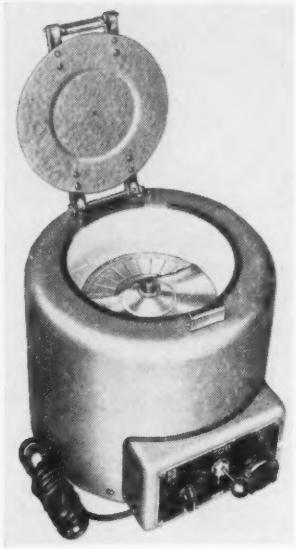


Here is a fully automatic device for providing controlled ventilation with alternating positive-negative pressure during anesthesia. It can be used to prevent respiratory acidosis, particularly during open-chest surgery, and to avoid circulatory depression in the hypovolemic surgical patient. This device is readily adaptable to any closed circuit anesthesia apparatus, and can accommodate automatically to requirements of each patient. Air-Shields, Inc.

325. Jaw needle holder

Holder has a jaw that will accommodate needles of different radius and size. It allows small french eye needles to be held at any place along the jaw without danger of needle breaking or turning. Available in 6, 7, or 8" sizes. OR Surgical Instrument Co.

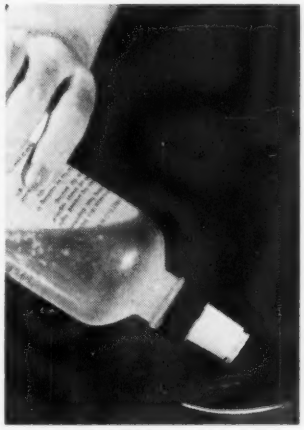
326. Clinical and hematocrit centrifuge

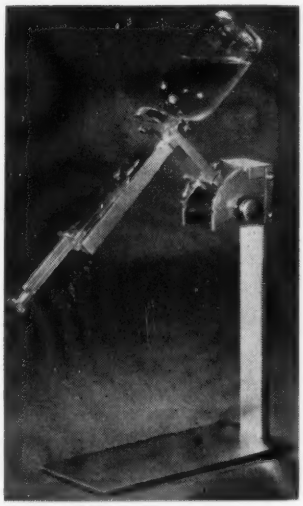


This combination clinical centrifuge with a special micro-hematocrit head gives up to 11,000 RPM on AC current. The head has 24 machined slots, each one numbered so that there is no possibility of confusing samples. A guard plate screws over hematocrit head to hold tubes in place while centrifuge is running. Centrifuge is 14" high and 14" in diameter; has grey metallic hammertone finish. Phillips-Drucker.

327. Liquid dispenser

Master liquid dispenser is designed primarily to be used by packers of liquid products for application to containers on filling line. Only one teaspoonful at a time pours from the new type of bottle that automatically measures out medicines. It is moulded of Bakelite vinyl resins. Isle of View Co.





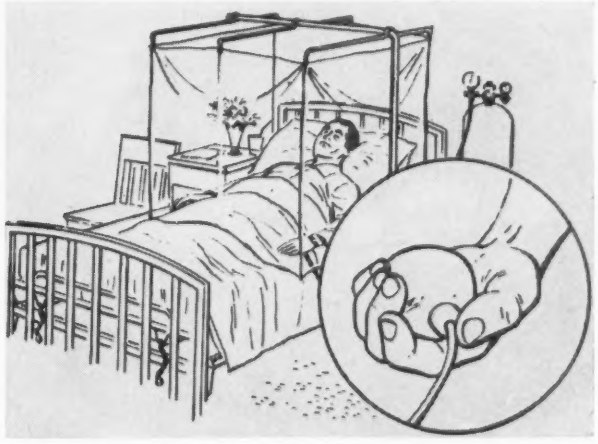
328. Syringe filler

Hypo-Matic syringe filler enables quick, easy filling and more accurate measurement of hypodermic syringes, the manufacturer says. It holds bottle and syringe securely and needle can be guided safely into bottle. Hypo-Matic is particularly suitable for mass inoculations, and is a time saver in office. It is solidly constructed and made of chrome-plated brass. Medical Appliance Corp.

329. Hospital radio pager

Private individual paging of doctors and hospital administrators is possible with pocket radio paging system. System individually pages staff members anywhere in hospital. Consists of selector console with individual buttons for key personnel, an FM transmitter that radiates alerting tones and voice messages within confined induction loop area, and the radio receivers themselves. As shown above, doctor can be reached privately by the radio paging system, even in the consulting room. Receiver fits comfortably into a suit pocket. Motorola Co.

330. Signaling from oxygen tents



A contact-less, explosion-proof locking button that eliminates the hazard of explosion in oxygen tents from old-type locking buttons has been announced. Compact unit constructed of nonconductive plastic. Sperti Farady, Inc.

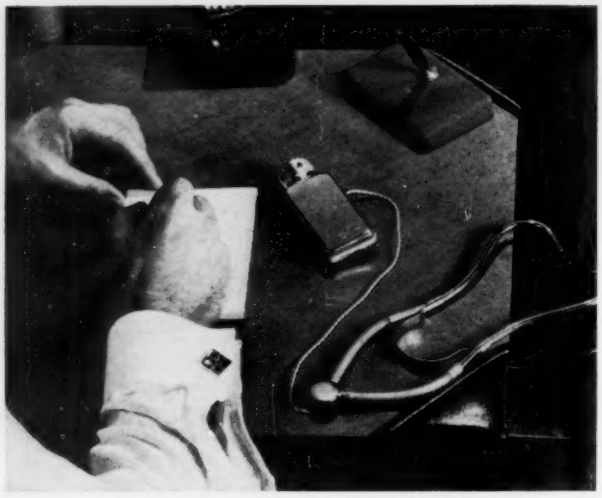
331. Surgical dressing

Petronet, the sterile non-adherent surgical dressing, affords painless removal, the manufacturer says. It is open-mesh gauze impregnated with petroleum jelly. Medical Aids, Inc.

BUYER'S GUIDE

Continued

332. Stethoscope

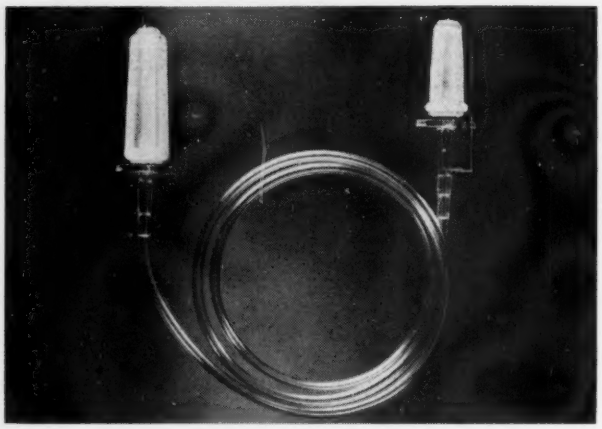


The Maico Stethetron, manufacturer says, delivers heart and chest sounds to the binaurals at 10,000 times the intensity obtained with acoustic stethoscope. Selective amplification gives greater emphasis to important tones; minimizes masking effect of other sounds. Improved transitor circuits for greater operating economy. Maico Co., Inc.

333. Pneumatic tourniquet

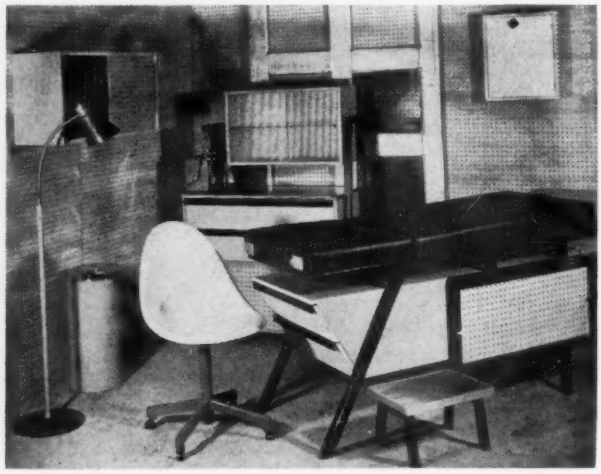
Only one size is needed for full hemostasis in adults and children. It gives complete access to the surgical neck of the humerus with a pressure pad that snaps on tourniquet sock and fits high up in axilla, and a harness that holds tourniquet on shoulder. One-buckle strap and hook keep the complete assembly in position. Varo-Met.

334. Tube for anesthesiologists



Expendable plastic extension tube for IV anesthetics. It is 20" long, and can be stretched to 30" to suit operative procedures or convenience of anesthesiologist. Fluid capacity of tube at any length is only 2 cc. Integral flanges on needle and syringe adapters make possible safe, quick connections and partings. Needle adapter flange holds needle in fixed position in vein, and keeps needle bevel from twisting. Pharmaseal Labs.

335. Examining room furniture



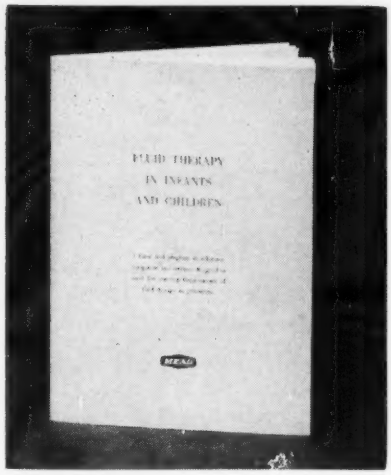
Furniture has all-steel construction, baked enamel finish, alloy castings, and Koroseal upholstering material. It features sliding door panels on storage cabinet; self-adjusting, disappearing stirrups and hidden paper roll. Combination of design of reception room and examining room furniture reduces the patient's fear, the manufacturer says. The furniture comes in eight standard colors and combinations. They are: opal grey-coral; opal grey-eggshell white; coral-eggshell white; coral-silver tone; ivory-eggshell white; mint green-eggshell white; mint green-silver tone; silver tone-opal grey. H. Martin Edgar Corp.

336. Swimsuits for breast amputees

Sea Plus is the name of a new line of swimsuits especially designed for breast amputees. Inflatable cups can be inflated to any size, then sealed by merely pinching the patented seal closed. Reform Corp.

FILMS AND NEW LITERATURE

350. Fluid therapy



Fluid Therapy in Infants and Children includes information on fluid balance in infants, common conditions of fluid imbalance, water and electrolyte requirements, technics for intravenous infusion and electrolytes of the homeolyte solutions. Mead Johnson & Co.

351. Oxygen therapy apparatus

New general catalog on complete line of Ohio Chemical & Surgical Equipment Co. therapy apparatus, and accessories. Featured are: oxygen tent, re-usable and disposable oxygen tent hoods, inhalation apparatus, infant oxygen tent hood, pressure regulators.

352. Film badge specification sheet

A two-page specification sheet describing film badges for personnel protection. Film in badge may be read for any gamma or x-ray radiation exposure between 50 and 300,000 milliroentgens.

353. Laboratory equipment catalog

This new 44-page illustrated catalog shows the complete line of lab equipment manufactured by Eberbach Corp. Features the lab shaker, electroanalyzers, slide cabinets, and other apparatus.

354. Fineness tester

Here is a bulletin on the precision-Blaine air permeability fineness tester for pharmaceutical powders. Precision Scientific Co.

355. Laboratory polyethylene

A 12-page publication on laboratory polyethylene ware. Introduced in publication is a new Ziegler process polyethylene. Palo Laboratory Supplies, Inc.

356. Scale error chart

Scale error chart issued by the education committee of the National Conference on Weights and Measures and the National Association of Scale Manufacturers, Inc., shows how small weighing errors quickly add up.

357. Hiring office personnel

How to Hire Office Personnel, a booklet explaining recruiting, screening, testing, reference checking, and interviewing of office personnel. Martin Publishing Co.

358. Institutional chart

Original chart as guide for institutions. Chart tells how to prepare and serve all present known types, sizes, portions, and weights of frozen fish. Included are pre-cooked, breaded, ready-to-cook, and raw for each of various size packages. Norwegian Frozen Fish, Ltd.

359. Hospital catalog

New 16-page price catalog is now available from Ethicon, Inc.

360. Testimonial plaque catalog

A special catalog in color devoted to testimonial and award plaques has been issued by United States Bronze Sign Co.

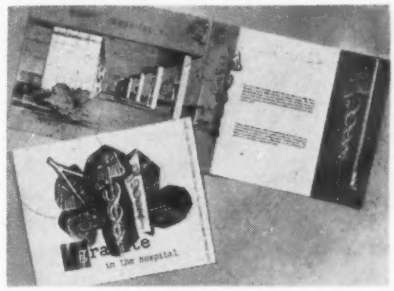
361. Electric parking gate folder

Here is a folder that explains how electric parking gates operate—using coins, keys, or tokens. Western Railroad Supply Co.

362. Emergency light folder

Four-page folder gives complete descriptions, suggested uses, and installation recommendations for Big Beam automatic emergency lights. U-C-Lite Manufacturing Co.

363. Granite for hospital architecture



This brochure develops a series of hospital sketches illustrating granite applications within and without hospitals. Cold Spring Granite Co.

364. Laboratory apparatus

Handy folder pictures and describes glassworking equipment used in the lab, such as burners, cut-off machines, and mercury cleaning apparatus. Bethlehem Apparatus Co., Inc.

365. Electronic sorter

Remington Rand electronic sorter, which sorts 48,000 special code-punched cards per hour, is described in illustrated folder.

366. Stainless steel equipment

Here is a 10-page booklet that tells all about stainless steel hospital equipment. Includes eight suggestions on cleaning methods. Armco Steel Co.

367. Gas chromatography analysis

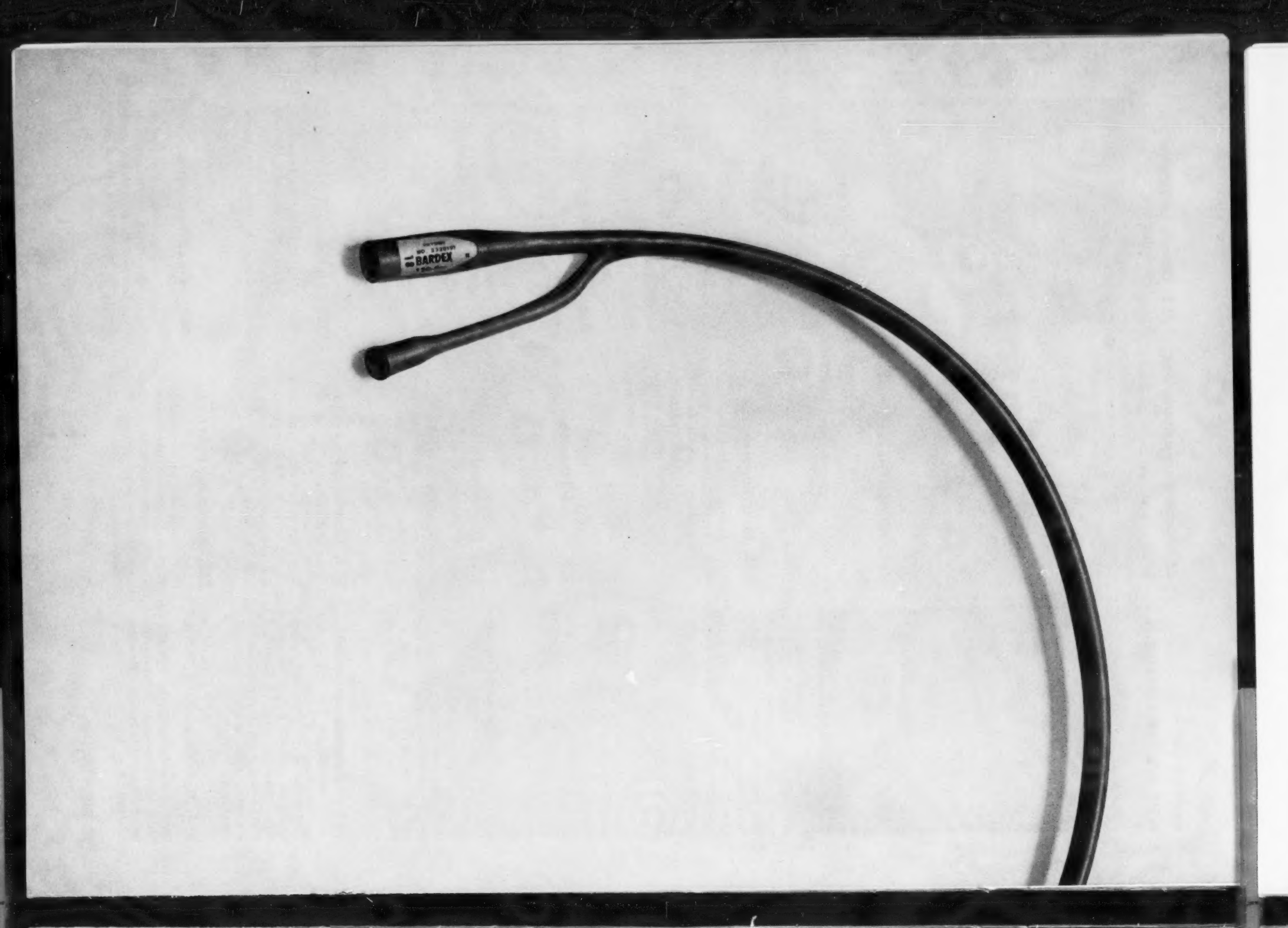
Booklet describes Kromo-Tog, the self-contained instrument for analysis of gases and liquids by gas chromatography. Burrell Corp.

368. Alphabetical tabulator

Alphabetical tabulator for translating punched-card data into printed form with totals as needed, is described in 6-page illustrated folder. Remington Rand.

369. Film on Mycostatin

Here is a 20-minute color film on therapeutic activity of Mycostatin in Candida infections. Available to medical groups from E. R. Squibb & Son.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REVIEW OF HOSPITAL

LAW SUITS

By Leo Parker, Attorney at Law

- **Proof of Negligence Necessary In Malpractice Suit**
- **Allergy Death Ruled Accidental**
- **Stockholders Can Liquidate Corporation**

A reader asks: "In a suit for malpractice, what must the patient prove to get damages from the hospital or attending physician?"

According to a late higher court decision, before a patient can recover in a malpractice suit he must prove first that the hospital or physician was unskillful and negligent, and second that the want of skill and care caused the injury to the patient. If either element is lacking in the proof, no case is presented for the consideration of the jury and the patient can recover no damages.

Details in the late case of Wade v. Ravenswood Hospital, 120 N. E. (2d) 345, tend to prove previously disputed legal principles. The plaintiff, Wade, said he remained in a tavern until late, watching television and having drinks—that he had no idea how many drinks he had or what time it was when he left the tavern, but that he went to his car and started home, and that his next clear memory was in Hines Hospital.

Police were called to investigate an accident shortly after 11 p.m. On arrival they found Wade's car, which had gone off the road and struck a lamp post and tree, demolishing the front end of the car. Wade was lying on the ground unconscious by the side of the automobile. He was placed on a stretcher and sent to the Ravenswood Hospital in a fire department ambulance.

A nurse at the hospital testified that Wade was brought into the emergency room of the hospital about 11:30 p.m., and was taken from the emergency room to a private room. Side rails were applied to his bed to prevent his falling out. Nurses applied ice bags to his head and stayed with him most of the night to see that he kept quiet. He was unconscious and stayed that way the biggest part of the night. His temperature and blood pressure were taken and routine treatments administered.

This nurse testified that she was with the patient almost constantly from the time he came in until she went off duty at 7 a.m., and that he was given chloral hydrate rectally in order to quiet him. She stated that she did not call an intern or resident during the night.

Dr. McGuire was called by a nurse about 7 a.m. and went immediately to the hospital. His first diagnosis was cerebral concussion and alcoholic intoxication. The patient had sand bags about his head and neck to immobilize the head. Dr. McGuire's final diagnosis was a cervical fracture and a cord injury.

Orders were given to keep the patient's head immobilized, and a roll was placed under his shoulders to prevent extension of the cervical vertebrae and certain cord injury. Sedatives were administered. X-rays were not taken. Dr. McGuire testified that after consultation with orthopedic surgeons it was apparent that there was a cord involvement and that it would not be prudent to disturb the patient by placing his head in different positions to take pictures.

Learning that the patient was a veteran, Dr. McGuire called Hines Hospital and made arrangements to have the patient transferred. He was removed to Hines Hospital in an ambulance, his head and neck immobilized by sand bags. After examination it was determined that Wade had a cervical cord injury, and his head was placed in halter traction.

Wade sued both Dr. McGuire and the Ravenswood Hospital for heavy damages. His legal counsel contended that Dr. McGuire was negligent and liable because (1) he made an improper provisional diagnosis; (2) he failed to take x-rays or spinal punctures; and (3) he failed to provide prompt immobilization and traction.

The patient at the time of the trial still suffered from a generalized paralysis. He had a constant aching and burning in his legs, but no touching sensation in them. He could move his arms and left wrist, but not his right. He had feeling in the top part of his arms but not in the bottom parts. He had no control of his urination and wore an inner catheter. He had no control of his bowels and had to be aided by mechanical agitation. He could not get in and out of his wheel chair unaided. There had been some clearing up of his mental condition since the accident, but no appreciable change in his physical disability.

The higher court refused to hold either Dr. McGuire or the hospital liable in damages to Wade, and said:

"It does not appear that any damage resulted to the patient, even though there might have been a faulty provisional diagnosis. Certainly within a few hours a definite final diagnosis was made on the chart, in the doctor's handwriting, of a spinal fracture. The failure to take x-ray pictures is explained in the testimony of the doctor that he was of the opinion that movement such as would be necessitated in taking pictures would not be good medical practice in view of the suspected injury. No one disputes the reasonableness of this conclusion. So far as immobilization and traction are concerned, defendant McGuire testified that when he first saw the patient there were sand bags about his neck, which is ordinary procedure to bring about temporary immobilization; and later in the day, when the patient was transferred to Hines Hospital, he continued to be so immobilized. We do not feel that the evidence shows any negligence in this respect. There is no proof that the treatment or lack of treatment received at Ravenswood Hospital aggravated these injuries."

For comparison, see the Supreme Court case of Bowles v. Bourdon, 219, S. W. (2d) 779. The court explained that a patient has no cause of action against his doctor for malpractice either in diagnosis or recognized treatment, unless he proves by a doctor of the same school of practice: (1) that the diagnosis or treatment complained of was

(Continued on next page)

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such as to constitute negligence and (2) that it was a proximate cause of the patient's injuries.

DEATH CAUSED BY ACCIDENT

If a patient ordinarily is allergic to ether and dies during a surgical operation, neither the hospital nor surgeon is liable or responsible, but the death is due to an unavoidable accident, according to a recent higher court decision.

In Swartout v. Holt, 272 S. W. (2d) 756, Mrs. Swartout sued Dr. Holt and his hospital for damages based on the death of her daughter.

During the trial the testimony showed that Mrs. Swartout took her 15-year-old daughter to a hospital operated by Dr. Holt for medical attention. The daughter had complained of pain in her abdomen and side, and appeared to be slightly nauseated. Dr. Holt advised an operation.

The mother, Mrs. Swartout, testified that she advised Dr. Holt that she objected to the use of ether as an anesthetic and explained fully to him the results of a prior operation. At that time the child had undergone a tonsillectomy in which the physician performing the operation had used ether as an anesthetic, and the child had collapsed and "passed out" while they were attempting to bring her under the influence of ether. The doctor gave her oxygen and artificial respiration to revive her. Dr. Holt said that he would use a spinal anesthesia.

However, Dr. Holt denied that he was informed prior to the time he began the administration of ether that the girl was allergic to it. The jury also decided that Dr. Holt had received no such information.

The testimony proved that when the patient was taken to the operating room she was given ether by Dr. Holt, and as a proximate result of receiving ether she suddenly became cyanotic and cardiac arrest occurred, causing her to cease respiration. She died in the hospital.

The jury decided that neither Dr. Holt nor the hospital was liable. The higher court approved the verdict, saying:

"The death of the child was the result of an unavoidable accident. The case was fully developed and the trial court submitted the cause to the jury on such theory. We have made a most careful examination of all the testimony tendered, and it is our view that the evidence is sufficient to sustain the answers of the jury thereto."

HOSPITAL CORPORATION IS INSOLVENT

According to a late higher court decision if a hospital is insolvent or has ceased to function, the stockholders, who paid for their stock, may have the corporation liquidated and have the assets distributed among themselves. However, holders of stock who received it without money payment are entitled to none of the assets.

In the case of the State of Tennessee v. C. M. Breedlover, 270 S. W. (2d) 582, a suit was filed on relation of five preferred stockholders who owned 70 shares of preferred stock of the Lake Haven Hospital, a domestic corporation incorporated in 1945. These five stockholders contended they they were entitled to liquidate the corporation and receive prorata distribution of the remainder of the corporate assets. They alleged that the hospital corporation had ceased to use its franchise, and was insolvent.

The higher court held in favor of the stockholders, saying that as the officers of the corporation had issued to themselves preferred stock without paying any money for it, they had no legal right to share in the assets to be distributed by the corporation. The court held:

"Where a corporation has ceased to function, or has become insolvent, or where it is impossible to attain the objects for which it was formed, a stockholder may maintain a suit to impound and distribute the corporate assets."

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303.	311.	319.	327.	335.	355.	363.	
304.	312.	320.	328.	336.	356.	364.	
305.	313.	321.	329.	337.	357.	365.	
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Nursing Care of Children with Pulmonary Fibrosis

Pediatric Nursing

By Mrs. Helen I. Mack, R.N., B.S.
Pediatric Supervisor
Illinois Research and Educational Hospitals
Chicago

● The nurse in charge of the child with pulmonary fibrosis is confronted with a great responsibility in executing proper management of so disabling a disease.

She must be emotionally ready to supply the guidance that the parents and child require. An understanding of both the organic disease and the emotional problem is essential. She must remember that we cannot cure these patients, but we can teach them to live with the disease.

What is pulmonary fibrosis? The older literature would refer to this condition as chronic pneumonia, interstitial pneumonia, or cirrhosis of the lung.

The extent of injury depends on the character of the injury to the lung and the duration. Injury may be incurred from external irritants, such as dust irradiation, or from bacterial, mycotic, and viral infections. Fibrosis also may arise as the result of internal injury by stress on vascular or lymphatic channels. If a cause is known, it is usually recorded as part of the diagnosis.

The specific causes of pulmonary fibrosis are:

1. Infections, such as bacterial pneumonia, tuberculosis, and histoplasmosis
2. Aspiration of mineral oil, vomitus
3. Cardiac disease, congenital and acquired
4. Systemic disease with pulmonary manifestations, such as cystic fibrosis and xanthomatosis

Clinically, pulmonary fibrosis is of interest because similar effects and symptoms are produced by a variety of diseases. Differences in opinion on diagnosis arise because of various interpretations of the procedures used to detect the presence of fibrosis. In many patients in advanced stages of the disease, it is difficult if not impossible to separate the disability due to pulmonary fibrosis from that of circulatory origin.

Fibrosis of the lung may be considered in three phases —first, its effect on ventilatory function; second, its effect on respiratory function, and third, its effect on the circulatory function. Usually more than one function is involved. It is a chronic disease, generally not diagnosed or brought in for treatment until the disease is far advanced and the function of the lung markedly impaired. Dyspnea is the most frequent symptom, with a cough a secondary symptom.

CASE HISTORY

The following case is a classic example of pulmonary fibrosis and illustrates the type of nursing care needed.

The patient, a two-year old white female, entered a private hospital with a history of cyanosis and respiratory distress of three-day duration. Extensive work-up failed to find the cause for the respiratory symptoms. She was hospitalized for six months.

Because of the many problems involved in such a prolonged hospitalization, including the necessity of continuous oxygen therapy and further diagnostic studies, she was transferred to Illinois Research and Educational Hospital. The child was brought in with oxygen and immediately placed in an oxygen tent.

She appeared chronically ill and markedly debilitated. She was extremely apprehensive, exhibited moderate generalized cyanosis, and whined throughout the admission. Her pulse rate was 124 per minute, temperature 99°, respiration 44 per minute. Her extremities showed marked clubbing of toes and fingers. Cyanosis of the extremities was more marked than elsewhere. It was noted that she could not be removed from oxygen for any period of time. Therefore, all procedures had to be carried out with her in the tent.

Her daily nursing care was standard as to bath, oral hygiene, shampoo, etc. However, more time had to be allotted because she became exhausted quickly.

In all cases oxygen therapy is of definite value during the acute respiratory embarrassment as well as in advanced stages. This child was placed in a tent with a canopy covering the 72"-long crib, giving her ample room to have her toys on the inside. At first her physical activity was restricted, so that she would not experience excessive fatigue or dyspnea. In pulmonary insufficiency

(Continued on next page)

the work entailed in breathing alone is sufficient to produce complete exhaustion of the patient's energy.

This child knew her own tolerance and came out from the oxygen tent spontaneously for short periods of time. She could not be pushed into activities because of this knowledge of her tolerance. When she was irritable, she would cry and bring on a cyanotic episode. The occupational therapist was very helpful in guiding her activities.

EQUIPMENT INSPECTION NECESSARY

Sudden rise in patient temperature may be due to faulty operation of oxygen equipment. Frequent inspection of inlets and outlets of the oxygen machine is necessary. Children will sometimes place food, toys, and crayons into the inlet or outlet tubes. These interfere with the flow of oxygen, thus causing a rise in body temperature as well as the temperature inside the oxygen tent. The tubing and the flow meter should be checked often. Sometimes with high humidity the children develop skin irritations which make them uncomfortable. The child in this case had 17 months of oxygen therapy.

Some time later, when the pediatrics department was moved to another floor, this child was more or less accidentally kept out of her tent for a period of two hours. At the end of two hours it was noted that she still remained quite comfortable and showed no signs of increased cyanosis or other respiratory distress. The nurses were requested not to place her back in oxygen and to notify the resident on the ward if any added respiratory distress occurred. She was watched closely throughout the remainder of that day. She remained quite comfortable. She was kept out of oxygen throughout that night and slept fairly well. Cortisone therapy was continued, and she remained comfortable without oxygen. Metacorten, cortisone, and ACTH are used in these cases to inhibit formation of granulation tissue.

The nourishment of the little girl was poor. Therefore high caloric, frequent feedings were given. Solid food at times was not tolerated. She became dyspneic and showed apprehension. A patient may regress to the point of asking for a bottle with a nipple. This child could suck and take a deep breath and control the flow from a bottle better than from a cup.

Patients with this condition cough up thick saliva, and so must be suctioned frequently or encouraged to expectorate. Another complication we noticed was abdominal distention, which was painful and embarrasing to the respiratory function. This was called to the doctor's attention. Enemas were ordered sometimes; if these did not help, other cathartics were given, such as fruit juices.

METACORTEN USED

The child continued to have a moderate degree of cyanosis which became more pronounced when she cried. Respiratory function studies were done, and it was decided to give her a trial of Metacorten. Clinical improvement was noted, but when respiratory studies were repeated, the findings did not corroborate the clinical improvement. The department of surgery examined the patient with a view to possible lung biopsy, but because of the diffuse process involved both lungs and because the child was still cyanotic, an operation would only have added to the difficulty in breathing.

Her Metacorten was dropped to 10 mgm. and she did relatively well. However, when it was further decreased to 7.5 mgm. daily, there was a definite deterioration in her condition. She tired more easily and exhibited an increase in her dyspnea and the severity of her cyanosis. When Metacorten was again increased to a daily dose of 10 mgm., a concomitant improvement was noted in her general condition with regard to dyspnea and cyanosis. She was discharged, to be followed in the outpatient clinic at weekly intervals.

PROBLEMS OF LONG HOSPITALIZATION

Children hospitalized for a long period become attached to the hospital personnel. Parents should be given an explanation of the behavior of such children and their need to substitute parent figures in the hospital. It should be explained to them that this emotional response is normal. The parents should be allowed to visit frequently with other members of the family to prepare the child for the home environment. In this particular case the parents were allowed to visit at any time and stay as long as they wanted. The mother came every day, helped with her care, watched the oxygen gauge, read stories, and helped with feedings.

When the child wished to drink from a bottle, the mother was assured that the child was not regressing. We stressed the fact that she was taking more nourishment through frequent 8-ounce high caloric eggnog feedings. Sometimes it was necessary to show the mother in figures how much the child had taken and what was given.

Emotional reaction to the child's illness shows wide variation. A mother needs a nurse who is responsive to her feelings. A social worker also is of great help in these problems. Long hospitalization brings many problems which are brought to the social service worker's attention.

At intervals the child must be induced to participate in group activity and not to stay in his own room. This will help to socialize the patient before discharge from the hospital.

Rehabilitation of these patients requires team work of the entire personnel. This includes the doctor, nurse, nurse's aide, occupational therapist, and the school teacher.

The parents leaving the hospital with the child depart with more ease than when they arrived. They have the assurance of what is expected, what to do. Return visits to the doctor's office for frequent check-ups should be stressed.

The child in this case returned for hospital readmission with the same symptoms after a two-month home stay. She died a month later.

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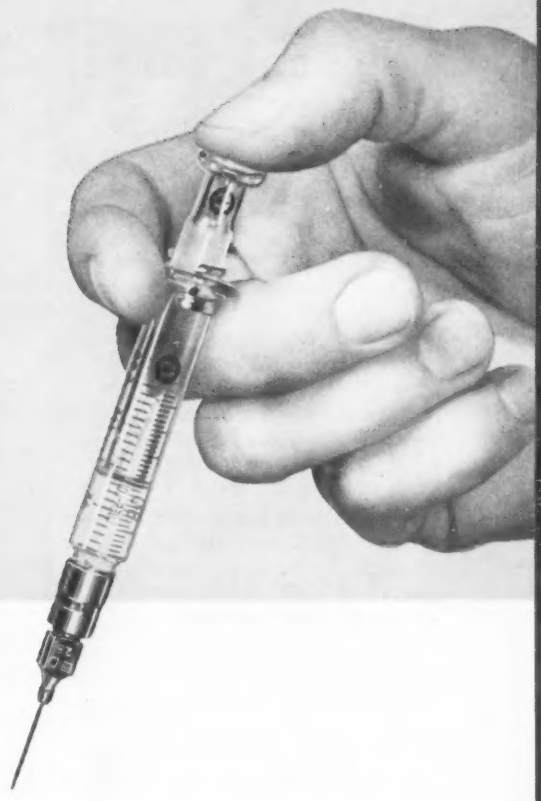

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The Book Corner

Hospital Literature Subject Heading List

Published by the Library of the American Hospital Association, Asa S. Bacon Memorial, 18 E. Division St., Chicago. The Library of the American Hospital Association has recently compiled one comprehensive listing of subject headings to be used in indexing periodical literature, in classifying pamphlet file material, and cataloging books. The new list represents a combination of lists used previously by the library.

Proper subject headings for the new listing were chosen with the help of librarians, editors, administrators and specialists in the various related fields of hospital administration.

A system of cross-indexing makes the listing clear and concise.

Main subject headings and subdivisions have been condensed as much as possible without loss of meaning. The general headings, "Hospitals," is intended to be used as the heading under which descriptive information on specific hospitals might be indexed.

Basic Nursing

Fourth edition revised by the teaching staff of the Household Nursing Association, Boston, and edited by Helen Z. Gill, R.N., executive director of the association. Published by the Macmillan Co., New York, 749 pages. Because the field of practical nursing is expanding so rapidly, the fourth edition of this text book contains the information needed by practical nurses for the more complex duties they are undertaking.

In addition to complete descriptions of her duties in the hospital, the authors have stressed the practical nurse's role in the family situation and her role in the home environment.

Portions of the text of the third edition which have proved helpful have been retained. The material on body structure and function has been separated from that covering the diseases of the various systems. The chapters on nutrition have been brought up to date with current diet therapy. The enlarged scope of the practical nurse's duties are pointed up in the addition of such subjects as intramuscular injections and oxygen therapy. Sections have also been added on care of the mother and child and care of the sick child.

Following each chapter is a short summary and a series of test questions.

Manual for Medical Record Librarians

By Edna K. Huffman, C.R.L., lecturer, Medical Record Science, Program in Hospital Administration, Northwestern University. Published by the Physicians' Record Co., Chicago, 604 pages, $9.75 a copy. In the fourth edition of her well-known book, the author has completely revised every chapter to include the very latest thinking and practice in the medical record field. There are 128 more pages than there were in the third edition, including 19 additional illustrations.

According to Mrs. Huffman, the aim of the book is to present the principles and practices of medical record science to assist in establishing sound organization and management of the medical record department. She has covered the elements necessary for a strong department organization, the aspects of department management, the components required in an adequate medical record, and the procedures and activities necessary to meet the requirements of the accrediting agencies.

Briefly, some of the subjects covered include: numbering and filing medical records; microfilming medical records; the standard nomenclature of diseases and operations; indexing procedures; legal aspects; medical terminology; the librarian's part in the medical audit; organization and management of a medical record department; and interdepartmental relations.

Respiratory Problems in the Premature Infant

Report of the Fifteenth M & R Pediatric Research Conference held under the auspices of Michael Reese Hospital, Northwestern Medical School, University of Chicago Medical School and University of Illinois College of Medicine, Chicago. Published by the M & R Laboratories, Columbus 16, Ohio. This conference was devoted to the premature infant and particularly to the respiratory problems. Interest centered on the physiologic and pathologic factors as they affect the infant. Discussions included consideration of the roles of the mother, the placenta, and the fetus.

Most of the papers dealing with the period following birth focus on clinical management, while those dealing with the earlier periods focus on physiology, pathology and the basic sciences. It was concluded that while great advances have been made in the management of postnatal respiratory disorders there is still much to be done for the prenatal period of fetal anoxia.

A new system of rapid cancer detection has been reported. Developed by cytologist H. E. Nieburgs, M.D., it uses an unusual Leitz microscope and picture screen combination. The screen looks like the picture tube of a television set. Technicians Paula Feniger (l.) and Henrietta Schachter, Beth El Hospital, Brooklyn, check patient history forms; the cell specimens are on small glass slides; technicians watch for unusual cells.

Texan Is Named Bioanalysts President

Marion F. Dooley, Dallas, Tex., has been named president, Council of American Bioanalysts.

The council is a national organization devoted to the scientific advancement of analytical laboratory directors in the biological and clinical laboratory fields.

Mr. Dooley succeeds William N. Reich, Diablo Medical Laboratory, Walnut Creek, Calif.

Additional officers include: Thomas S. Hosty, director of laboratories, State Department of Public Health, Montgomery, Ala., president-elect; Victor Dozoretz, Dozoretz Clinical Laboratory, Buffalo, N.Y., vice-president; Gustina Zimmerman, Zimmerman Laboratory, Flint, Mich., vice-president; and Frank Kolos, Physicians Clinical Laboratory, San Francisco, vice-president. Elisabeth Zacher, Oakland (Calif.) Clinical Laboratory, was elected treasurer, and Lucien Hertert, Hertert Clinical Laboratories, San Francisco, executive-secretary.

Hospital Pharmacists Announce Officers

Paul F. Parker, Chicago, is the new president-elect, American Society of Hospital Pharmacists. He will be installed at the annual meeting, April 8, 1956, in Detroit.

The vice-president-elect is Milton Skolaut, Bethesda, Md. and the treasurer-elect Sister M. Berenice, St. Louis, Mo.

Mr. Parker is chief pharmacist, University of Chicago Clinics.

Columbia Gets $100,000

The Fannie E. Rippel Foundation of Newark has awarded a $100,000 grant to Columbia University for research on cardio-vascular-renal diseases and cancer.

Few Doctors Over 65 Retire

While many physicians restrict their activities after 65, general retirement at that age seems not only undesirable, but impossible, a recent survey revealed.

Medicine in the News, published by the Schering Corp., sent a questionnaire to physicians over 65. It showed: (1) eight of every 10 are still in active practice; (2) one of every two sees more than 40 patients in an average week; (3) one of every four treats patients of all ages; one of every two sees chiefly patients between 40 and 60, and (4) one of every four will handle all types of cases. Three of every four do not accept surgical cases.

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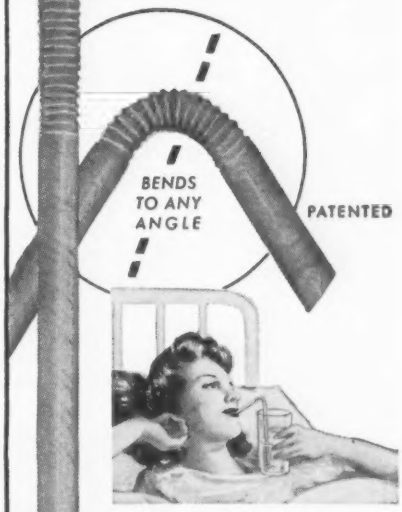

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American College of Surgeons O. B. Abstracts

Papers from the American College of Surgeons' meeting which are of particular interest to the obstetrical staff are abstracted here. Abstracts of other significant papers from the meeting are found in the convention report, beginning on page 11.

Survival Chances Cited For Rh Problem Pregnancies

No Evidence That Early Termination Helps

What is the outlook for a woman who has had one erythroblastotic baby? If the mother becomes immunized during a first pregnancy and the baby lives, there is a 50 percent survival rate for succeeding pregnancies. If the first child dies, the survival rate drops to 25 percent. If the baby is stillborn, the next pregnancy has a 10 percent survival rate. Thus the outlook is never completely hopeless.

Every woman should have an Rh test done during every pregnancy. If Rh immunization is found, the antibodies should be determined. Usually the higher the titer, the poorer the outlook. However, even a low titer can result in a stillbirth.

There is no evidence that early termination of pregnancy helps. The majority of severely affected babies are usually delivered prematurely anyway.

At delivery of an Rh-immunized mother, preparations must be made for immediate blood tests on the baby and for exchange transfusion. The objective is to prevent prolonged jaundice, which damages the brain. Bilirubin determinations are done every four to eight hours after the transfusion. If the bilirubin level is kept down for 48 hours, the baby is safe. Occasionally small booster transfusions are needed at the end of six or seven weeks.

In a study done at Chicago Lying-In Hospital on 6,000 Rh-negative women, it was found that 2.3 percent of the pregnancies were lost. Of this number, 1.3 percent were from other causes, while one percent were stillbirths caused by erythroblastosis.

One out of every 20 Rh-negative women is immunized from blood transfusions or previous pregnancies. All Rh-negative women should be carefully delivered of the placenta. Most damage is done during delivery if Rh-positive blood escapes into the bloodstream.—**Edith Potter, M.D.,** Associate Professor, Department of Obstetrics and Gynecology, University of Chicago.

Cardiac Output May Vary 50 Percent in Childbirth

Uterine Contraction Associated With Change in Output

Cardiac output may vary by over 50 percent during successive phenomena associated with labor and delivery, we found in a study of over 50 patients, in whom we measured alterations by the blood pressure method.

An effective uterine contraction is associated with a marked—and predictable—pattern of change in cardiac output. Ineffective uterine contractions, and contractions induced by the administration of oxytocics, are accompanied by changes of lesser magnitude and lesser predictability. The cardiac output rises consistently but transiently during actual delivery of the infant. Subsequent rises in output are noted at placental separation and/or the initial postdelivery uterine contraction.—**Edward J. Quilligan, M.D.,** and **Charles H. Hendricks, M.D.,** Department of Surgery, Western Reserve University School of Medicine, Cleveland.

Signs of Shock May Appear Late in Obstetric Cases

Although maternal mortality has decreased, deaths from blood loss in obstetrics continue. Hemorrhagic shock produces renal and pituitary damage.

The obstetrical patient, because she is usually young and healthy, adjusts to considerable blood loss without exhibiting shock, and when first signs of shock do appear she is in serious condition. Too often, blood clotting dyscrasias complicate blood transfusions administered to stabilize the patient.—**Duncan E. Reid, M.D.,** Professor of Obstetrics and Head of the Department, Harvard Medical School.

Inhalation Anesthesia Favored in Obstetrics

Offers Rapid Induction; Can Be Stopped Any Time

Choice of anesthesia in obstetrics depends on the doctor's familiarity with the drug, the type of trained personnel available in the delivery room, and its fitness for a particular patient.

No one anesthetic is perfect, but the inhalation type is best. It offers rapid induction, the depth of anesthesia is predictable and reversible, and it can be stopped at any time. It is contraindicated if the mother has a full stomach or an upper respiratory infection, or if the delivery is premature.

Of the inhalation-type anesthetics most commonly used, nitrous oxide is rated as excellent. It is non-toxic and fast. It is not too good a muscle relaxant, but is good for intermittent anesthesia. Its explosability is low.

Another excellent anesthetic is ethylene. Its advantages are rapid induction and recovery. It is explosive, but the risk is less than with some other inhalation anesthetics.

Cyclopropane has a high oxygen concentration, but it is very toxic and is potentially dangerous and lethal. The fetus does not get the oxygen, but it does get the toxicity.

(Continued on next page)

Trilene is not too good, because any self-administered anesthetic is unsafe. It should never be followed by a closed-system anesthetic.

Spinal anesthetics should be reserved for only those patients in whom a general anesthetic is contraindicated. Effects such as headaches, allergic reactions, and sudden hypotension preclude the use of spinal anesthesia.—**Ralph A. Reis, M.D.**, Professor of Obstetrics and Gynecology, Northwestern University, Chicago.

Chloroform Called Excellent Anesthetic for Obstetrics

Risk Involved Less Than Half That for Other Agents

When used with care and understanding, chloroform has less than half the anesthetic risk of other commonly used obstetrical anesthetics.

We highly recommend it to anyone looking for an obstetrical anesthetic which offers ease of administration, safety for the mother and baby, complete pain relief, and unexcelled relaxation for all obstetrical maneuvers.

We reviewed cases of 209,000 patients who were given the drug for childbirth over the last 20 years. The toxicity of chloroform to both the heart and liver has been stressed in medical teaching for many years. However, in these 209,000 cases there were only 10 deaths from cardiac arrest and one from toxic hepatitis, or a total mortality rate of one in 19,000 cases.

Continuous electrocardiographic monitoring was used during 100 chloroform anesthetics to determine the incidence and type of cardiac irregularities. In the second stage of labor the patient was taken to the delivery room for a preanesthetic electrocardiogram of the six standard leads, to rule out any unsuspected pre-existing cardiac lesions. The electrical activity of the heart was then monitored throughout the anesthetic with an oscilloscope attached in series with the direct writing EKG machine.

Whenever an abnormality was noted on the oscilloscope screen, a tracing was made for a permanent record and later detailed study by a cardiologist.

Ventricular tachycardia was found in one-third of the cases, and other minor abnormalities were found in an additional 30 to 50 percent, depending on whether supplementary oxygen was given under the mask. All observed abnormalities reverted spontaneously to a normal rhythm following recovery from anesthesia.

Surgical plane anesthesia is obtained in five minutes with chloroform, and the excitement phase is short. Recovery from anesthesia is rapid. Although vomiting is not infrequent, aspiration is uncommon.

There is little harmful effect on fetal respirations. Respirations were spontaneous in 91 percent of 60,000 chloroform anesthetics studied by Lenahan and Babbage.—**Paul T. Buerger, M.D., George M. Sanderson, Jr., M.D.,** and **Albert N. Rekate, M.D.**, Department of Obstetrics and Gynecology, University of Buffalo School of Medicine, Buffalo, N.Y.

"Oh, I feel fine today, but it's probably just my nerves."

Furor Over Unjustifiable Hysterectomies Not Warranted

Data Lacked Substantiation

The furor over unjustifiable hysterectomies is the result of two surveys in which results were evaluated on the basis of patient response and not physician experience. The information was poorly assimilated, and the data lacked scientific orientation. More reliable information collected since has not shared in this publicity.

A working formula for a survey in this area is impossible to organize. There are too many factors involved, meriting individual consideration, to make large-scale analysis practicable. Hospital records are too often brief and sketchy. Pathological diagnosis needs more careful scrutiny. The presence of positive pathology is certainly the only indication for hysterectomy. The mechanism of uterine bleeding is too poorly understood and the indications for removal of the uterus too varied among gynecologists to allow any one decision to be the ultimate. The indications for hysterectomy in preventive medicine further complicate an analysis of this kind.

The profession will continue to be acutely critical of hysterectomies.—**George H. Gardner, M.D.**, Chicago.

Some Depression of Fibrinogen With Intravenous Pitocin

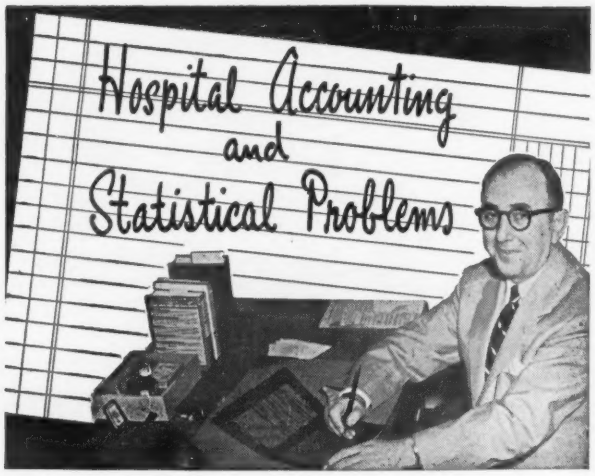
No Bleeding Noticed

We studied 30 patients to determine the safety of intravenous Pitocin administration from the standpoint of inducing hypofibrinogenemia. It previously had been reported that tumultuous labor will introduce thromboplastin into the circulation, thus causing intravascular clotting and subsequent hypofibrinogenemia and bleeding.

The patients were divided into two groups. Group I consisted of 15 patients with spontaneous labor and uncomplicated deliveries; Group II consisted of 15 patients who received intravenous Pitocin for induction. Five minims of Pitocin were administered slowly in 500 cc. of five percent glucose water. The average duration of labor in Group I was nine hours; in Group II, three hours.

There was no significant change in fibrinogen level in Group I. In this group the levels were taken pre-delivery, 30 minutes, three hours, and 24 hours after delivery. In Group II there was a depression of fibrinogen in the pre-delivery specimen and in the four-hour postpartum level.

Despite a decrease of 20 percent, no bleeding was noticed. The subclinical hypofibrinogenemia encountered in abruptio placentae and a macerated stillborn fetus may be aggravated by intravenous administration of Pitocin and change the subclinical dyscrasia to a manifest one. Unless rapid delivery with intravenous Pitocin can be expected, it should not be given under these circumstances.—**Andre Marquis, M.D., R. R. Margulis, M.D.,** and **David Ucker, M.D.**, Woman's Hospital, Detroit.



By David H. Tarlow, C.P.A.

Senior Partner, D. H. Tarlow & Co.

Hospital Accountants and Auditors, New York City

Q. I am taking a position as administrator with a voluntary hospital on February 1, 1956. Can I make arrangements with the board of trustees to pay part of my salary into an annuity contract with an insurance company to effect a tax saving?

A. Yes. A nonprofit institution can arrange to pay part of a person's salary to an annuity contract. This part of the salary will not be reported as income to the employee when the annuity is being purchased, but is deductible as part of the operating expenses of the hospital. At such time as an employee receives the benefits from the annuity, he then picks up the income and pays a tax thereon. For your guidance we quote the section of the Internal Revenue Code applicable when the nonprofit hospital makes an agreement with an employee to pay part of his salary to an annuity or insurance company.

Under Section 403 (a) (1) of the Internal Revenue Code of 1954:

"If an annuity contract is purchased for an employee by an employer described in Section 501 (c) (3) which is exempt from tax (nonprofit), the employee shall include in his gross income the amounts received under such annuities (contract) *for the year received* as provided in section 72 (relating to annuities) except that section 72 (e) (3) shall not apply."

EXPLANATION: Nonprofit institutions can arrange to pay part of a person's salary to an annuity contract. This part of the salary will not be reported as income to the employee, but is to be deducted as part of the expense of the hospital. Of course, when the employee receives the benefits from the annuity, he is taxable in full for these benefits.

We would further suggest that you review your contract with legal counsel before signing.

* * * *

Q. The president of our board was named trustee of an estate which pays income to a life tenant and names the hospital as residuary legatee. An examination of the assets of the estate showed that such consist almost entirely of bonds purchased within the last five years. Some of the bonds were purchased at a premium and others at a discount. I have been asked to set up accounting records to determine the payments due the life tenant. Can you give me any assistance in this matter?

A. This problem appears to be adequately answered in the following excerpt from the text of Dr. W. A. Paton on the subject of "Bonds Representing Special Funds":

"Where funds are set up for particular purposes, and are invested in bonds at a premium or a discount, care must be exercised to insure the maintenance of the integrity of the fund, and this means that the line between principal and income must be carefully drawn. It seems clear that a special fund invested in bonds at a premium is not maintained intact unless the trustee (or other responsible party) takes care to amortize the premium systematically and to treat such amortization as a recovery of a part of the principal rather than as income. It seems equally clear that in the case of a fund invested in bonds at a discount the accumulation is income rather than principal (although it does not follow that it should be disbursed as such prior to payment of the bond at maturity or earlier).

In the case of an estate or other special fund invested in bonds at a discount, there is no danger of disbursing more than the actual income. In this case the party entitled to income is handicapped by the fact that in each period during the life of the bonds the amount collected is less than the true income, and there appears to be no practical obligation on the trustee to make disbursements in excess of the amount collected. Nevertheless, a proper accounting in this case also requires the setting up of the full income per period, including accumulation, and ideally some provision should be made for placing this income in the hands of the proper party as it accrues. In the case of the decease of the party entitled to income prior to the maturity of the bonds and the collection of the discount, an obvious injustice is done."

* * * *

Q. We have 125 employees and are revising our payroll system. We would appreciate any guidance you can give us as to which type of pay period you recommend, i.e.:

Weekly

Biweekly

Monthly

Semimonthly

A. We would suggest that you use a biweekly pay period. While there may be some accounting detail required for accruals at periodic closings, we believe the advantages enumerated below far outweigh any inconvenience:

1. Preparation is easy when deductions must be made for time off.

2. Employees are better able to understand deductions when there is no question of a short or long work period, as in semimonthly payments.

3. Monthly payments oftimes result in need for advances and depletions of petty cash funds.

4. Weekly pay periods require too much time from a small administrative staff.

We might further recommend that you review the numerous multiple-form payroll systems available: i.e., Shaw-Walker, Hadley, Todd, etc.

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Patient-Centered Care

By Edythe L. Alexander, R.N.*

(The following paper and the one on page 77 was presented at a panel discussion on "Staffing the Operating Room in Relation to the Future," at the 1955 A.O.R.N. Convention in St. Louis.)

● Optimum care for patients requires the vision, vigilance, and research of all persons who are concerned with or participate in its production, but essentially it depends upon the leadership provided.

Today, many operating room nurses try to supervise solely by retaining personal and individual relationships with their surgeons, nurses, and workers. This is no longer possible within our modern operating rooms. Group action has succeeded individual action. Now the supervisor-staff member relationship is increasingly that of group to group. Building upon this approach, the employee and employer may lose some values, but the advantages gained by the groups and the patients offset the losses.

To improve nursing service, the graduate nurses must be given freedom in which to work and develop paths of communication so that they can extend their ideas to those who are carrying out nursing duties. In itself, this is not easy; but the path to patient-centered care becomes less arduous if we accept the group approach, and if we use good management and teaching skills. In the operating room, the graduate nurses must develop better working plans and utilize all opportunities to evaluate new and old procedures, and help their co-workers to observe and evaluate the patient's needs as a basis for giving care.

We would all agree that the persons who enter our operating rooms as patients are very important people. We would agree that the people who care for patients are important. At least we give lip-service to this philosophy. We know that good nursing care is given when all personnel carry out their prescribed tasks correctly, completely, and safely. We also know that optimum care requires expert assistance from the personnel in other departments in the hospital—the bacteriologist, the pathologist, the engineer, the nursing teams stationed in the units, the supply room, and the recovery room, as well as the educational leaders, the medical staff, and the administrators.

Our modern operating rooms comprise a network of interrelated and interdependent parts within the hospital. Sometimes the interrelationships and interdependence are not recognized until we try to make changes, such as installing new equipment, revising a procedure, or employing a new group of workers. In order that the best care may be given to all patients, there must be a real relationship between the patient and those who are giving the care, between the supervisor and those who are being supervised, and between the supervisory group and persons in other departments.

(Continued on next page)

*Miss Alexander is assistant editor, **American Journal of Nursing**, New York City.

Panel members were (l. to r.): Sr. Mary Susanne, dean, St. Louis University School of Nursing; Mabel Northcross, ORS, Homer G. Phillips Hospital, St. Louis; Sr. Oliva Brusch, R.N., director of nursing education and nursing service, Evangelical Deaconess Hospital, St. Louis; Ethel West, R.N., Methodist Hospital of Southern California, Los Angeles; Edythe L. Alexander, assistant editor, American Journal of Nursing. Miss Alexander's paper appears above; Mrs. West's is on page 77.

In some situations the patient is accepted only as a body whose complex anatomical structure and function is diseased or injured. Yet we know that the sick person places a great value on our services, and we also know that his attitude may be quite different when he is well. To the patient, the physician and the nurse stand for security, the relief of suffering, and the hope of recovery. Do we underestimate the value of this association? We also should remember that a person looks upon his body as a mystery of complex design and function which is understood by the physician and nurse. Today, we are aware of the delicate interplay between the mind and body, and realize that many diseases that are surgically treated have components of both a psychological and physical nature.

CONSIDER PERSONAL MOTIVATION

When we help our personnel, do we take into account personal motivation, family background, and existing social pressures? Do we develop a group approach in caring for our patients? If we agree that both the patient and personnel are important, we see our tasks revolving within a system of human relations.

The gowned, masked personnel who hurry down the halls as they pass the worried patients, the many instruments lined row upon row on the numerous draped tables, the odor of disinfectants, the searching lamps, the buzzing saw, the placing of a patient on the operating table as if he were a contortionist—all are necessary in our operating room, but they push away the personal, gentle touch in caring for patients. How the personnel accept their duties and work together influence and often determine how the patients accept their problems.

In good impressions, the patient sees his operating room experience, through the members of the nursing team, as a place where kindly, considerate, and thoughtful people are concerned about his welfare. Do we allay anxiety regarding the anesthetic, the insertion of an endoscopic tube, the insertion of a Kirschner wire, and many other procedures to which our patients are subjected? Do we stop to wonder how a patient feels about them?

If we employ sympathy and gentleness, we can realize and appreciate more deeply the patient's feelings and difficulties. The act of surgery requires gentleness, yet gentleness is too often taken for granted. Too often we assume that it will be applied by each person who helps care for the patient. The practice of gentleness can be a conscious habit. The team member uses her voice and her hands with gentleness consciously, because she knows it is good nursing. When the nurse or attendant places the patient on the operating table, she uses thoughtful, objective gentleness, based not upon sympahy alone but upon knowledge that the malignant tumor of the lung is an incessant source of human fear, and that proper positioning may help control the cancer cells. Habitual gentleness develops from the worker's understanding of the disease, the medical standards, and technics, as well as from experience and the ability to identify herself with the human race.

NEED FOR GRANTING AUTHORITY

To provide good relations between the patients and the people who are caring for them, our organization chart must give all workers the authority to work together with the patient. Our traditional charts depicted a series of closed boxes rather than a series of concentric spheres. Ideally, this sharing and communicating extends out in all directions, to and from the patient. Horizontal or technical specialization has been applied in industries, because it has made possible the vast increase in mechanization. Mechanization in the operating room can in turn reduce the patient's costs for care, and it can contribute to better nursing care.

If functional authority is planned around the patient, the first group surrounding him includes the staff nurse, the technicians, the attendants, and the nursing aides, as they have the closest contact with the patients. The professional graduate nurse in this group is aware of the patient's total needs and is responsible for seeing that they are fulfilled. She prepares, administers, and supervises the care of patients who are assigned to her rooms. She knows the scientific basis for and applies aseptic principles in carrying out procedures. She helps teach the nonprofessional personnel the technical skills of their job; she interprets to them the patients' needs.

The general staff nurse also participates in the administration of the service. To give good care the professional nurse can no longer be content to carry out repetitive tasks that are required in some procedures, and to carry out orders given to her only by the supervisor or surgeon; she also must be ready to interpret to others what she sees, to evaluate the needs of the service, to observe and evaluate the worker's performance, and relate these facts to her leaders.

As a professional nurse-practitioner she works with other human beings as a contributor to the improvement of the service. In our preoccupation with management technics, the tremendous advances in surgery, and the scientific discoveries which have been adapted to surgery, we must keep before us the purpose for which they exist—to give care to patients. So let us be certain the special skills of the professional nurse are therapeutic as well as highly technical.

The chart's second circle is wider, since the head nurse's functions include a wider range of activities. The head nurse has closer contact with the nursing teams and the supervisor than with the patient, but her efforts are directed in helping the personnel provide good nursing care to all patients. She has become an essential person in the operating room because of the advances in surgery, the use of modern technical equipment, and the increase in the number of nonprofessional workers. All her activities are directed toward the patient as she works with the nursing teams, the surgeons, and the supervisor. She is responsible for providing a high quality of care, for conserving costs, for providing proper opportunities for the staff's growth, and for creating an atmosphere for good nursing and personnel job satisfaction.

In making the daily assignment with the graduate nurses according to the plans agreed upon by the supervisor and staff, the head nurse considers the patient's needs, the approximate time necessary to carry out the tasks, and each team member's ability to perform these tasks.

MAY GIVE DIRECT CARE

There are times when the head nurse gives direct care to patients; that is, she may "suture" or "circulate" as she teaches a staff member, or she may help out in an emergency situation, or give care for personal growth.

The third circle of our chart is again widened, since the supervisor's activities include guiding and directing all nursing personnel in the department. The supervisor accomplishes her tasks by directing the efforts of the staff through planning, directing, controlling, and co-ordinating the service, so that the care of the patients will be done correctly, safely, and completely. The supervisor acts as an administrative multiplier by guiding and inspiring many people to carry out those duties that she knows will benefit the patients. But this job is not a desk job for the entire day. She must see the service that is given to judge correctly and to identify the weaknesses and strengths in the staff's performance. She evaluates nursing service so that she can establish goals and find ways to achieve them.

The supervisor believes that learning results in changing a person's behavior, and that it is more likely to occur if the worker knows and accepts the reasons for learning a task. She also realizes that she must determine how far the personnel have gone in reaching perfection in their tasks.

Although the supervisor has close contact with the head nurse and graduate nurses, her functional authority is surrounded by a larger circle—those of the administrative and hospital service groups. From a horizontal view, she shares with other hospital groups in providing services. She is the interpreter of the needs of her service to the nursing service administrator, and of hospital policies and aims of nursing service.

There are several essential factors that must be accepted if the functions of the operating room nurses are to be clearly defined so that effective nursing care will be given. First, we must examine the objectives and aims of each position in the department. This is accomplished by a group approach to nursing service, so that better working plans can be developed. We must consider how to create a good atmosphere in our department for the patients and workers. In caring for the patient we must use objective gentleness and recognize his problems.

We must use functional authority as a means of defining the professional nurses' functions and their relationships with other workers in the department.

Perhaps the most meaningful advance that we can make toward patient-centered care occurs when we ourselves actually put into practice our belief that the patient and the people who give this care are important people. Your gentleness, your positive attitude towards patients and personnel, your counseling skills, your understanding of the feeling involved and the causes behind your own performance, your acceptance of help and advice from others, your ability to interpret principles of administration and management, your desire to study and evaluate methods, your faith in yourself and others—these things will help you as leaders of your co-workers who help care for the patients.

The Role of the Surgical Technician

By Ethel I. West, R.N.*

● You may not like it, but surgical technicians are here to stay. So why not accept them graciously? Instead of being mentally antagonistic toward them, why not use their assistance to advantage?

If you analyze the situation, you will find them necessary. We must recognize that hospitals are faced with a serious problem. The number of patients entering our hospitals has increased, while the number of professional nurses staffing the opertaing rooms is inadequate. As a profession we are dedicated to the relief of human suffering. The public looks to us for help. We cannot refuse.

A solution has to be found to relieve the increasing pressure. The logical solution to this problem of inadequate supply of professional nurses is to supplement them by training nonprofessionals for more valuable assistance in the operating room.

Years ago, all the housekeeping was done by professional nurses, but now we realize it is a waste of talent and education which should be utilized to better advantage, leaving the housekeeping duties to auxiliary personnel. We have become accustomed to having a great deal of the repetitive tasks done by an auxiliary group. We welcome new procedures and new equipment, but it is quite another matter when they affect personal feelings and attitudes. There must be more flexibility in our thinking. The modern concept of administration is to encourage workers to develop competence in their profession. Technical competence is important, but the ability to understand and lead a group is an outstanding quality. We all know that teamwork is essential in the operating room.

What is teamwork? It is a concerted effort by a group of people working together. They must have a common purpose or plan. The plan must be well organized, completely understood, and accepted by all team members.

Our whole routine in the operating room revolves around a team. Why not make the surgical technician a member? Let us briefly review some of the duties of this team. Much is expected of the operating room supervisor. Her duties seem endless. Among her many attributes must be leadership. Every leader realizes the importance and value of everyone on the team contributing her best toward making the team plan workable and effective. The operating room supervisor, in order to give maximum service to the patient, must appraise the value of each member of the team and direct her individual talents and ability to obtain her best contribution. Any variation from usual procedures, whether it concerns procedures or equipment, should be explained.

Another important member of the team is the professional staff nurse. She must be taught to develop leadership and teaching ability. Teaching is a skill that can be learned, and in the learning the staff nurses themselves will acquire greater skills and increase their

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*Mrs. West is operating room supervisor, Methodist Hospital of Southern California, Los Angeles.

own knowledge. By their own attitude they will inspire confidence, poise, respect, and admiration. In a teaching program the standards of the hospital are benefited. Also, this program will prepare auxiliary personnel to perform certain functions with safety and understanding.

WILL NOT REPLACE R.N.

I do not believe that surgical technicians will ever replace the professional nurse, but they can fill a present-day need for operating room personnel. Before a surgical technicians' program is started, the hospital's standards and policies must be determined. The need for surgical technicians and their functions should be interpreted to the medical staff. Both doctors and surgery personnel may be saved future embarrassment if all are familiar with the duties of the technicians.

Careful selection must be made of the candidates applying for these positions to determine their qualifications. Technicians are not professional people. They have not taken the training and studies required for graduation for professional nurses; so their duties and responsibilities are limited. Their reactions vary. Their potentialities and capabilities must be determined to see where they are best fitted. Some have manual dexterity and make good suture nurses. Others may be slow to adjust and may require more guidance, but by constant application can be developed. They must constantly work under supervision and must be developed to meet the needs of the hospital.

A program of instruction should include formal teaching, demonstrations, discussions, and problem conferences. To be effective, the level should not be placed too high. It should be simple, concise, and well planned, but adapted to meet the requirements necessary to give effective instruction. Situations vary with each hospital, and no set pattern can be used routinely.

Each individual should be made to realize that she is an important member of a team whose sole purpose is to expedite the recovery of the patient. To be effective as a team, team members must not only know their own duties, but understand the functions of the rest of the group.

An in-service training program should be started during the technicians' orientation to the operating room unit and to the hospital. Ethics should be stressed so that they know how to conduct themselves, not only in surgery, but elsewhere in the hospital.

Daily assignments should be given and procedure books and cards used to demonstrate standardized technics.

How soon a technician is able to function without direct supervision depends on the skill and ability of the individual, but she should always be responsible to the professional nurse.

Conferences at stated intervals, including all members of the team, are important. Questions should be encouraged and suggestions given consideration. The participants should provide the material for demonstrations and discussions, as far as possible.

In a technicians' teaching program, orientation should include introduction to supervisors and personnel and a tour of the operating room suite and hospital, with conferences covering:

1. Aims of program, operating room and hospital ethics and policies, with relationship to other personnel
2. Line of authority in the hospital and O.R.
3. Responsibility to patient
4. Legal responsibility
5. Safety in the O.R., including precautions necessary against fire and explosion hazards
6. Care in the prevention of industrial accidents.

SUBJECTS TO COVER

Some of the subjects for discussion and active demonstration are:

1. Short basic course in anatomy
2. Classifications of operations
3. Nomenclature
4. History of surgery
5. Principles of asepsis
6. Sterilization—history, methods, and principles
7. Sutures—history, types, uses, and sterilization
8. Needles and knife blades—varieties, use, and sterilization
9. Assembling of packs
10. Opening and handling sterile supplies
11. Autoclaves—mechanism and operation
12. Tables, lights, cauteries, and other electrical appliances—care and function
13. Syringes—care and sterilization
14. Hand scrub
15. Gloves—care and sterilization
16. Gowning and glove technic
17. Instruments—care, sterilization, and assembling of basic sets, special sets
18. Draping of patients
19. Positioning of patients
20. Contaminated technic
21. Drugs and solutions
22. Anesthetic equipment—including assembling, cleaning, sterilizing of IV sets, spinal sets, caudal, and local
23. Preparation of patient's skin
24. Casts and responsibilities of orthopedic equipment
25. Cystoscopies—preparation, care of equipment
26. Assistance in transferring patients from ward to O.R. and back to recovery unit or ward
27. Care of specimens
28. Care of other equipment and facilities which is not the responsibility of the housekeeping department.

After completing the course of formal classes, technicians can be taught to scrub as second scrub nurse on major cases, and as solo scrub nurse on minor cases, and become capable of circulating on most types of operations.

How successfully the surgical technician works depends on the acceptance of the program by the professional nurses. Capable, intelligent supervision, given by professional personnel willing to teach and lead, will help to establish a well-organized, efficient department. Skill is important, but the professional personnel must be sympathetic to produce results.

The program is a challenge to the professional nurse to continue her own educational program and to keep up with new developments and procedures. It appeals to the individual's desire to develop a feeling of per-

sonal worth. The technicians' value to the department will increase to a greater extent if the technicians know they are wanted and accepted.

The professional nurse must realize that the surgical technician will never replace her, but will rather strengthen her position in the O.R. If you are in an operating room in which surgical technicians are already employed, or one in which the hospital contemplates using them on the O.R. staff, take advantage of the situation. Upgrade yourself by becoming efficient as a leader or teacher.

We must face realities and solve our mutual problems wisely and with a feeling of great responsibility to our patients.

The A.O.R.N. Problem Clinic

Part 2

*Questions and answers on common operating room problems**

MODERATOR: Elliott Hurwitt, M.D., Chief of Surgical Division, Montefiore Hospital, New York City

Participants:

SURGEON: Cyril Costello, M.D., Medical Director, City Hospital, St. Louis

ANESTHESIOLOGIST: Seymour Brown, M.D., Chief, Department of Anesthesia, St. John's Hospital, St. Louis

ADMINISTRATOR: William H. Andrews, Administrator, Peoples Hospital, St. Louis

DIRECTOR OF NURSES: Anne Campbell, R.N., Director of Nurses, Barnes Hospital, St. Louis

OPERATING ROOM SUPERVISORS: Capt. Margaret J. Whitton, ANC, U.S. Army Hospital, Fort Leonard Wood, Mo., and Mrs. Frances F. Ross, Former Operating Room Supervisor, John Gaston Memorial Hospital, Memphis, Tenn.

OPERATING ROOM INSTRUCTOR: Mrs. Sarah Marks Giddens, R.N., Operating Room Instructor, Lincoln Hospital, New York City

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DR. HURWITT: I wish we all had Dr. Brown heading our anesthesia departments.

Here's a question which is directed to Miss Campbell, but I think she may want to pass it on. Let me preface it with this question: Miss Campbell, do you think that the nursing administrator or the operating room supervisor should schedule the cases?

MISS CAMPBELL: I think that the operating room supervisor, with the cooperation of the anesthetist, should schedule the cases.

DR. HURWITT: Then, Mrs. Ross: In regard to elective surgery, how late do you schedule your last case?

MRS. ROSS: Of course that's up to the individual operating room. At our own hospital we stop operating at 5 o'clock. I must explain that ours is a teaching hospital, and we have students of all types. Our scheduling is very different from the private hospitals. If at 4 o'clock we have a radical mastectomy to do, we know we can't finish by 5, so we cancel. If we have a small operation, such as an excision of a lipoma, which we can finish by 5 o'clock, we do not cancel.

DR. HURWITT: Mrs. Ross, will you comment on the scheduling of emergency operations after the surgeon's office hours.

I presume that the questioner means that an emergency has come up and there's time available, and the surgeon says, "Well, I'll come up when I finish my office hours."

MRS. ROSS: I think that the operating room supervisor cannot make all these decisions alone. If she can work with the anesthetist and the chief of surgery, they can form a committee to solve all these problems and form definite policies. The committee can support her decisions. If policies are written down in black and white, then she can say, "This is it," and make no personal differences at all. We all know that we may like a certain surgeon and we don't want to interrupt his office hours because we want him to see all the patients that he can. Yet we cannot say, "All right, we'll just stay here and wait for you," because if we have a vacancy and he needs to do that emergency, then certainly I feel he should utilize the time available.

DR. HURWITT: Of course, there are emergencies and emergencies. There are the emergencies that have to be done "stat," and there are those that require a few hours of preparation on the part of the patient before the surgery should be done, and there are the cases that should be done within the next few hours but shouldn't wait until the next day. I think you're pretty much dependent on the judgment of the surgeon as to the character of the emergency that he's handling.

Here are two questions for Mr. Andrews, both about a recovery suite. The first is: Who should be responsible

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*Transcript of a panel discussion from the Second National Conference, Association of Operating Room Nurses, St. Louis, January 24-27, 1955.

for the recovery room? Should it be under the O.R. supervisor, or should it be a separate department with a department head?

MR. ANDREWS: I'm not really in a position to answer that question fully, because I do not have a recovery room in my hospital. But I believe it should be a separate department headed by the anesthesiologist.

DR. HURWITT: Here's the second question before I go back to that first one, because I think that will stand some discussion. Should the patient be charged for the use of the recovery room? Do you feel this works a hardship on him, and how could one eliminate this procedure?

MR. ANDREWS: I do not feel that the patient should be charged, because I think the primary reasons for the innovation of a recovery room are to help solve the nursing shortage and to relieve the surgical nurse from having to take care of the postoperative procedures. I think the unit really is a convenience for the hospital.

DR. HURWITT: There's no question that it is a great convenience for the hospital and effects a great saving in personnel all around. At our hospital, where we have a really first-class recovery unit, there is a charge for the private patient who does not have a special nurse. The charge is $1.50 an hour, which by the time the month is over just about balances out the running of the recovery unit. The ward cases of courses are not charged, and the cases who come in with their special duty nurses are not charged.

I'd like to go back to the first question and toss it to Dr. Brown, but first let me ask you, Dr. Brown, is anesthesia a separate department in your hospital, or is it under the chief of the surgical division?

DR. BROWN: We are considered a part of the surgery division, but there's never been any interference in anything I wanted to do as head of the anesthesia department. If there is anything at all that might be debatable, I discuss it with the chief of surgery ahead of time.

DR. HURWITT: Now who do you think should be in charge of the recovery unit?

DR. BROWN: I feel that the anesthesiologist should be in charge of the medical aspects of the recovery room, and that either the director of nurses or the O.R. supervisor should be in charge of the nursing aspects, under the direction of the anesthesiologist.

I feel that the unit is not purely a convenience for the hospital personnel. That was not the original idea, and I don't think as far as the patient is concerned that it is a hospital convenience. It's an actual safety measure; it's a better form of treatment. I think that we should not lost sight of this fact.

DR. HURWITT: Our recovery room is run nursing-wise not under the supervision of the operating room supervisor, but under its own supervisor, who functions as a unit under the surgical supervisor, who functions under the director of nurses.

Our department of anesthesia is in the surgical division, and the anesthetist and the surgeon share in the professional responsibility for the recovery unit. No patients can leave the recovery unit without having been seen and signed out by a member of the anesthesia or surgical departments.

Here's a question for Dr. Costello: How do you differentiate between major and minor procedures? Does the procedure itself, the surgeon, or the length of time involved, have any bearing on the category?

DR. COSTELLO: I don't know that this question can be answered. Those who have studied it at length, because they're interested in the economic aspect of medicine, have not been able to elucidate it completely. What may be a minor operation so far as technic or time is concerned may be major because of a coincident illness, whether it be diabetes, heart disease, or something else. I don't know exactly what facet of the problem prompted the question. Ultimately the decision as to whether surgery is major or minor must rest with the surgeon.

DR. HURWITT: I think that probably some hospitals have their operating room charges based on categories such as this.

DR. COSTELLO: For information on this subject, I think that one can refer to the Blue Shield, which has made perhaps the best study as to what is major and minor.

DR. HURWITT: Dr. Costello, are nurses obliged to bring coffee or any food for the anesthesiologist in the

operating room? If they do not, what do they do about his griping?

DR. COSTELLO: This is into the operating room?

DR. HURWITT: Yes!

DR. COSTELLO: Why, I would say, no! My delay is more in my amazement than in my decision. I would say emphatically "no!"

DR. HURWITT: How about you, Dr. Brown?

DR. BROWN: Very emphatically, no! In fact, maybe I'm a tyrant, but we don't have coffee at all. We feel that the schedule is very important. There's time for lunch, and we can get our coffee then.

VOICE FROM THE AUDIENCE: Dr. Hurwitt, I think that surgeons become irritable, as most men do when they become hungry. I think that considerable irritability in operating room activities is sometimes relieved by serving orange juice or milk between cases—not in the operating room, certainly, but some place nearby, perhaps the staff room or locker room—particularly for those house officers and others who are going to be spending most of their time in the operating room during the day, and that includes the nurses.

DR. HURWITT: I find that such a practice ends in more and more procrastination, and there's more and more irritation at the end of the day when the operations aren't finished.

Now, here's a question which we'll hand to all of the administrative personnel here, starting with Mr. Andrews: What policy is followed for overtime?

MR. ANDREWS: In the first place, nurses should be asked to come back or to be on call, and they should be given additional money for any time they are asked to be on call. Certainly a nurse who has to stay in the field with an operation that lasts over her certain period of time should also be given overtime, which would be approved by the administrator.

DR. HURWITT: Miss Campbell!

MISS CAMPBELL: Our policy is that all nurses, regardless of whether they work in the operating room, are paid for overtime or given the time back. I think sometimes they prefer the time. But it must be either given back or paid for within each pay period.

DR. HURWITT: Anyone else on the panel care to answer that?

MR. ANDREWS: Dr. Hurwitt, I think that it is much better to pay the employee than to allow overtime to accumulate. If you let a nurse accumulate time and then give her a certain amount of time off, I think that practice will eventually run your schedule very far behind. I would recommend that the employee be paid.

DR. HURWITT: Here's a question for both the operating room supervisors, Mrs. Ross and Capt. Whitton: Should the circulating nurse measure blood loss in long cases, such as lung resections?

In most hospitals this is under the supervision of the anesthesiologist, but in many hospitals systems have been set up for measuring blood loss roughly, by weighing sponges.

In some hospitals this is done by a member of the house staff; in others, by a member of the anesthesia staff, and in still others, by a circulating nurse.

CAPT. WHITTON: If we notice an extreme amount of blood loss, we inform the anesthesiologist. He will come in and decide for himself. Of course, the doctor notices the loss also. The anesthesiologist usually tells the doctor that there seems to be a greater amount of blood loss than usual and asks whether he would like for the patient to receive a transfusion. Many times the blood has already been ordered and is at hand to be given to the patient.

DR. BROWN: The actual technic would have to be decided locally. I don't think anyone could make any definite rules, but as far as we are concerned the anesthesiologist is the one who is carefully observing the blood loss and the one who orders the administration of it according to the rate he feels that the hemorrhage or loss of blood is occurring. We have never consulted the surgeons about it. I don't say this in a deprecatory manner, because they've put their confidence in us, to conduct the anesthesia in the most physiologic manner possible.

DR. HURWITT: You don't actually have any technic for measuring it?

DR. BROWN: No, it is a purely clinical one. We watch the amount of blood going into the suction bottles, note the condition of the patient, check the number of large sponges and the small sponges being taken out, and

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note how well they are soaked. There is frequently much fluid being irrigated into patients, so that weighing under those circumstances can be a source of error.

DR. HURWITT: Miss Campbell, how can time be arranged for in-service education programs during duty hours?

MISS CAMPBELL: I think that one way to do it is to set up an in-service program with a set time when nurses are allowed to attend such meetings, if your scheduling can be arranged around it. It's difficult for all people to get there, particularly operating room personnel, but a certain percentage certainly can be allowed to go.

DR. HURWITT: Mrs. Giddens, do you have any suggestions?

MRS. GIDDENS: We send a representative from our operating group to in-service programs. A report is given to the group in the operating room by the individual who attended.

DR. HURWITT: Who is responsible for teaching medical students and interns scrubbing, gowning, and gloving technic? Do they receive any formal instruction in surgical aseptic technic? Dr. Costello!

DR. COSTELLO: Very frequently I've found that they don't—but they should. Medical students should be given very careful classroom instruction on aseptic operating room technic. They should be given demonstrations before they come to the operating room, and then they should begin under the supervision of some member of the surgical team. In many institutions it turns out to be the intern or the assistant resident.

The individual who ultimately is responsible for seeing that the standard of the technic is carried out, whether by an intern, a medical student or a staff surgeon, is the operating room supervisor. She should be given full authority to call attention to any breaches of technic.

It is not her responsibility primarily and should not be pushed off on her to see that everyone who comes in is taught the technic. Students in particular should be taught before they arrive, and should be supervised by a member of the surgical team.

DR. HURWITT: Capt. Whitton, do you treat dirty cases separately from clean cases?

CAPT. WHITTON: Yes, we certainly do, if it's at all possible. Of course it depends upon whether we're overseas or whether we're in the United States. In the United States it is easy to do. We try to separate them, either by partition or screening of some kind, and of course use the best technic that we possibly can.

DR. HURWITT: Is there anybody on this panel who does not treat dirty cases separately from clean cases? (No replies) I guess that answers the question. Mr. Andrews, please explain the co-operation given the operating room supervisor by the hospital administrator.

MR. ANDREWS: An administrator has to cooperate with every department head in the hospital, not only the operating room supervisor but every other department head. He should be behind the operating room supervisor to help her enforce staff rules. Certainly all of this will be done through cooperation with the medical staff. I think the administrator has a definite responsibility to stand behind the operating room supervisor in all of her problems in working through the director of nurses.

DR. HURWITT: Dr. Brown, here's a series of short questions: How much conversation should be carried on with the patient after he receives his preoperative hypo?

DR. BROWN: Very little.

DR. HURWITT: Should the O. R. supervisor visit the patient postoperatively?

DR. BROWN: I see no particular reason for it.

DR. HURWITT: Would you advise giving Pentothal to adults for tonsillectomy?

DR. BROWN: I personally do not.

DR. HURWITT: Should a patient's head be kept flat after spinal anesthesia?

DR. BROWN: That is a long-accepted custom. It is not really necessary, but in order to avoid confusion in nursing care we adhere to it. Actually, I was fortunate enough to do a series of several hundred cases, and found that in the postoperative period following use of spinal anesthesia it makes very little difference in what position the patient lies.

DR. HURWITT: What about the use of spinal anesthesia or Pentothal for patients who are highly allergic to medication?

DR. BROWN: That question is difficult to answer specifically, because it all depends upon the type of allergy.

DR. HURWITT: Let's say you have an asthmatic. But Pentothal would be definitely contraindicated because of its pharmacologic action.

DR. BROWN: I think it's important that that point be clarified. In some persons' minds these two agents may be classed as anesthetics, and therefore comparable, but physiologically their action is entirely different. One of the major hazards in giving Pentothal is the possibility of bronchospasm or laryngospasm. Patients have been lost from those complications when facilities for an adequate airway were not immediately at hand. One of the prime actions of spinal anesthesia, on the other hand, is as a relaxant.

DR. HURWITT: May I add that when a patient has undergone a major surgical procedure it is necessary, of course, to keep him down or perhaps in slight Trendelenberg position for a couple of hours.

Mrs. Giddens, as the degree program shortens student experience in the operating room to four weeks, where will the R.N. obtain instruction and experience to prepare her for the position of supervisor?

MRS. GIDDENS: We do not have the college program. Our students get eight weeks in the operating room. Upon graduation they can attend a college and get a B.S. or master's degree that gives them some instruction to qualify them for teaching or administration in any field of nursing.

DR. HURWITT: Miss Campbell, would you answer this question? Also, should this period of postgraduate training be financed by the school or by the hospital?

MISS CAMPBELL: In answer to the first question I think that we all must realize that even a nurse who is graduating from a four-year program with an R. N. and a B. S. is prepared only for first-level positions.

I don't think that we are trying to prepare nurses for operating room supervisors right after they graduate from schools of nursing.

So far as getting her specialized training, I think that she's going to have to get it on a graduate level, along with experience. I'd like to underline experience because I think that is very important to an operating room supervisor. As for who should pay for the training, I think a person's education is something she should finance herself. Perhaps she is fortunate in being in a hospital which has scholarships or loan funds. I know that many hospitals are sending nurses away for training and are financing that training or putting the nurses on scholarships, in order that they may come back to the hospital as better trained employees. Such programs are, I think, very helpful and certainly are improving nursing care throughout the country.

DR. HURWITT: Mrs. Ross, do you think preoperative preps should be done by the O.R. personnel, or by the floors?

MRS. ROSS: We have found at the University of Tennessee that if the student nurse does the prep on the floor, she has an excellent opportunity to see the patient prior to surgery. She enjoys this very much; she has an opportunity to teach him, to give him health guidance, to help prepare him for surgery.

DR. HURWITT: Dr. Costello, do you permit your resident surgeon to start the operation without your presence on service cases?

DR. COSTELLO: Yes, in many instances.

DR. HURWITT: So do I, depending on the case, and on the resident. And I think most of us will. "Without your presence" I think means "presence in the operating room." The attending surgeon, or the surgeon of record, in all cases must be in the hospital and must have notified the operating room to go ahead before the resident surgeon is permitted to start the case.

Capt. Whitton, providing contaminated clean-up technic is used after a sigmoidoscopy on an outpatient with poor enema results, is the procedure to be allowed in the operating room suite routinely?

CAPT. WHITTON: Say the chief of surgery has special cases that he would like to have done in surgery. We have a minor room in which these cases are taken care of. Our same contaminated procedure is used for one of these cases. Of course there's no need to wash down the walls. But the instruments definitely are soiled and are taken directly to the instrument sterilizer-washer.

DR. HURWITT: Dr. Brown, how do you care for equipment following a contaminated operation?

DR. BROWN: If you mean just an ordinary incision and drainage type of operation, there is no reason to do other than the usual cleaning of our anesthesia equipment, especially inhalation equipment.

DR. HURWITT: Do you autoclave or cold-sterilize your ampules for spinal anesthesia?

DR. BROWN: We cold-sterilize our ampules for spinal anesthesia. I know that this is now being debated very hotly among various anesthesiologists, but we have yet to have a complication, and I know that in some cases where they have autoclaved such ampules there has been some degeneration in pharmacological activity.

DR. HURWITT: Mrs. Giddens, how long are students assigned to the O.R. in your hospital?

MRS. GIDDENS: For eight weeks.

DR. HURWITT: Are they used for service at that time, or just for observation?

MRS. GIDDENS: I don't care for the words "service" or "coverage." I like to say that the students are in the operating room for learning experience.

DR. HURWITT: When do you feel the student's mind is most receptive for surgical experience?

MRS. GIDDENS: I believe students should come to the operating room in their second year in training, after they have finished their experience on the medical and surgical service.

DR. HURWITT: If a student wishes to continue in the O. R., how do you advise her?

MRS. GIDDENS: I advise her to take a postgraduate training course at a hospital that offers an advanced course in O. R. technic.

DR. HURWITT: Miss Campbell, should the surgical supervisor be under the director of nurses, or directly under the administrator?

MISS CAMPBELL: I believe that the surgical supervisor should be directly under the director of nurses.

DR. HURWITT: Mrs. Ross, what can an O. R. supervisor do about surgeons who refuse to observe operating room policies in regard to aseptic technic?

MRS. ROSS: Again, I would like to emphasize the importance of co-operation between the anesthesia department, the chief of surgery, and the O. R. supervisor. If you can, set up your policies so that there is a definite answer. For instance, we say that if anyone sees a break in technic he should say something about it and correct it.

If the surgeon will not co-operate I think the matter should be brought up before the committee. I really don't know the answer; I've had the same problem. But most of the time, if we are tactful with the surgeon and talk to him personally, he will co-operate.

DR. HURWITT: Dr. Costello, what would you suggest as basic equipment for a cardiac arrest tray—instruments, drugs, etc?

DR. COSTELLO: There are several articles that every operating room supervisor should read if she has no other access to this information. There have been several articles from Bellevue Hospital by Dr. Hugh Stevenson and others. Dr. Frank Lahey wrote on proper equipment set-up for the operating room, and, incidentally, this equipment might well be considered for other places than the operating room alone.

DR. HURWITT: More important than the exact equipment necessary on a cardiac arrest tray—as Dr. Costello has pointed out, you can get this information from a number of articles—more important than that is the point of view—that the first person to arrive at the bedside of a patient who has suffered cardiac arrest should be the person to open that patient's chest. We have not yet in our hospital had the experience of a nurse's opening a patient's chest, but if she did she would not be criticized for doing it. If the only instrument handy is a pair of bandage scissors, the chest should be opened with those scissors.

Actually, everybody who dies, dies of cardiac arrest.

(Continued on next page)

What we mean by the term is sudden stoppage of the heart unexpectedly in a patient who is undergoing or has recently undergone a surgical procedure. Under those conditions, opening the chest promptly and massaging the heart are mandatory. You can look for somebody else after you've opened the chest, but if you don't get the chest open there's no point in looking for anybody else.

DR. COSTELLO: Dr. Hurwitt, I would add a word of caution to what I consider your enthusiastic approach. It is still required that a physician determine when a patient is dead. Occasionally the diagnosis of death may be a problem, and certainly the differential diagnosis of cardiac arrest and peripheral vascular shock may at times pose quite a problem, particularly to nurses.

DR. HURWITT: I accept your recommendations with reservations, because I've seen many doctors err the same way. We have had the experience of having the chest opened—and we don't open them as freely as do personnel in many hospitals—and then seeing a heart that is not actually arrested but beating very feebly, and with a little massage and probably on its own equally well, will recover. I would much rather have this happen a dozen times a year than have half a dozen patients lost in genuine cardiac arrests who might possibly have been saved.

Mr. Andrews, do you think it is necessary for an O. R. supervisor to have liability insurance?

MR. ANDREWS: No, I don't. I feel that since the O. R. supervisor or nurse is an agent of the hospital, it is the responsibility of the hospital to carry such insurance. There have been many test cases in which this subject has come up. I feel that if a hospital has used good care in selecting its employees, and can prove that due care has been taken and that there was no negligence on the part of the nurse, it certainly would win the case.

DR. HURWITT: Of course what usually happens is that when something goes wrong at least three people are sued, usually four—the surgeon, the anesthetist, the operating room supervisor, and the hospital. Now it's your opinion that the hospital should assume all of this responsibility. For the surgeon too?

MR. ANDREWS: I feel that possibly the surgeon should carry his own liability insurance. Again, I think that if it can be proved there was no act of negligence on his part, he will win the case.

DR. HURWITT: Unfortunately there has been in various parts of the country an epidemic of building up cases against surgeons, many of them totally indefensible cases on the part of the complainants, but cases having an enormous nuisance value—because once a physician is brought up on charges of professional misconduct or of professional negligence, it really doesn't matter very much whether he wins the case or not—he is smeared in the eyes of the community. As a result, almost no cases ever get to trial. Any surgeon who does not carry the maximum of malpractice insurance is very ill advised, no matter what sacrifices he has to make in order to carry it. Many persons have found themselves ruined, in debt for the rest of their lives, because of having been brought up on charges which may or may not have been justified, but which have been decided in favor of the plaintiff.

Capt. Whitton, how often do you have conferences with your staff, and at what time of day?

CAPT. WHITTON: The chief of surgery has a conference with the operating room supervisors and the surgical floor supervisors once every two weeks, preferably in the afternoon when the cases have been completed.

DR. HURWITT: Would you discuss the ordinary care and cleaning of a gas machine, Dr. Brown?

DR. BROWN: Basically, the primary responsibility of a gas machine is with the one who is using it. Before one ever administers anesthesia to a patient, he should always check whether or not the valves are working and whether or not oxygen and all the other gases, particularly oxygen, are available in sufficient amounts. The primary responsibility will always devolve onto the anesthetist, but all the necessary equipment relative to that gas machine should be there also before the operation is started.

Secondarily, we have our anesthetists check each gas machine daily and replace airways and endotracheal equipment, so that any and all equipment is in perfect order for use at any time. After each patient is anesthetized, the tubes and the mask are all washed thoroughly with aseptisol soap and rinsed, and then allowed to dry. As far as wiping the machine, of course, that is a matter of housecleaning.

DR. HURWITT: Mrs. Giddens, should student nurses be taken from the O. R. to attend surgical and medical ward conferences?

MRS. GIDDENS: Yes. Attendance at medical ward conferences by student nurses has value as a review period. Attendance at surgical conferences is very valuable in observing the over-all picture of patient care—the preoperative, operative, and postoperative aspects.

DR. HURWITT: Mrs. Ross, here is a question that comes up every year: How do you get the surgeon, particularly the visiting surgeon, to wear his mask above his nose?

MRS. ROSS: This always happens to an operating room supervisor! There are some operating room supervisors who have the idea that you can tell the surgeon what to do. I don't believe that. I think he should be asked in a tactful way if you may pull the mask up. So many times that method works. Try it.

DR. HURWITT: How do you handle the problem of doctors, pathologists, etc., who aren't wearing O. R. apparel who want to come in the O. R.?

MRS. ROSS: I think any person going into the operating room should wear a scrub suit. Of course he must not wear his woolen pants into the room. We get a lot of co-operation from the anesthetist on this problem.

DR. HURWITT: Here's a question which I think is very important, and I don't know to whom to address it. How does the salary of the O. R. technician compare with that of the registered nurse? Miss Campbell?

MISS CAMPBELL: I would say that the O. R. technician is probably in the same category as the prepared practical nurse, and that the usual run of the salary is two-thirds that of the registered nurse.

DR. HURWITT: Dr. Costello, in small hospitals where resident physicians are limited, is it permissible for a graduate nurse to serve as first assistant in a major operation?

DR. COSTELLO: Definitely, yes. And there are many advantages to this practice. So far as surgical technic is concerned, some of the prettiest performances I have witnessed have been in hospitals away from medical centers, in which the same nurse assistant has worked with surgeons over a period of years. As far as the technic is concerned, there's no reason why she can't learn it as well as an individual with an M. D. She is serving as a technical assistant, pure and simple.

DR. HURWITT: I'd like to re-enforce that. Some of the best help that I had during the war years overseas on a Navy hospital ship was from registered nurses. Unfortunately, there was not enough of that. They had so many other duties to perform that frequently major surgery was done just with the help of a 17-or 18-year-old boy who'd had a few months of O. R. experience.

Capt. Whitton, what can be done to keep powder from flying all over the rooms when powder packs are being used? The gloves and powder are put on in the area of sterile instruments.

CAPT. WHITTON: We usually are away from the instruments when we put on our gloves. When we aid the physician, we also keep the powder away from our instruments. Physicians are gowned and gloved separately, in the same room, of course, but not right on top of the instrument table. A damp towel is placed over a pail in one corner of the room. The doctor then powders his hands over the pail. This helps prevent the powder from flying around the room.

DR. HURWITT: Mr. Andrews, here's a touchy question for you: If much of your elective surgery is unnecessary in a hospital with no medical audit, what can be done? We are not referring to illegal procedures, but to removal of normal tissue—normal appendices, normal uteruses, normal gall bladders. This is a very serious practice throughout the entire country.

MR. ANDREWS: I think this matter would be taken up through the staff. Certainly most hospitals of today have a tissue committee, which would report on this type of thing, and of course if it found a man was doing unnecessary surgery certainly the matter would be taken to the executive committee or the medical staff, and action would be taken by that group.

DR. HURWITT: Unfortunately, in many hospitals where this is done the executive committee is impotent, or contains the men involved.

What about the wearing of operating room dress, with masks hanging loose, when not on emergency errands? Why do personnel wear them in the dining room? They are soiled and grimy. How can this practice be stopped?

MR. ANDREWS: I think it's just a matter of using a little tact, and I don't think that there's any definite rule that you can follow. Sometimes it is necessary for a doctor to leave an operation and go to the dining room in his scrub suit, because he may have an appointment or another operation to go to.

DR. HURWITT: Dr. Brown, what do you consider a satisfactory arrangement between the M.D. anesthetist and the hospital? When should the M. D. anesthetist charge the patient for the administration of the anesthetic agent? If the M. D. anesthetist gives several spinals in succession and the R. N.'s employed by the hospital sit with the patient, should the hospital be reimbursed? If so, at what rate?

DR. BROWN: There have been several surveys on this subject, and there are as many opinions as there are surveys. So it's impossible for me to give you any definite answer. It depends to a certain extent on the locality in which you're working, and what the arrangement is in that locality.

DR. HURWITT: It's a matter of economics that varies tremendously in different parts of the country too, depending on the policies of the county medical society and the difficulties that the local anesthetists are having with the supreme board of anesthesiology.

Mrs. Ross, how much time do you allow between cases?

MRS. ROSS: In our hospital we set up each operation individually, for from 20 to 30 minutes.

DR. HURWITT: Should the O. R. nurse on call be compensated for on-call time, regardless of whether she works or not?

MRS. ROSS: That's up to the individual hospital. In our hospital no one takes call, because a nurse is on duty at all times. If she is on call at home or takes call from a room provided in the hospital, perhaps her overall salary can cover this inconvenience, and she will not have to be paid for each individual call.

MISS CAMPBELL: I think the question is debatable; however, we do not pay nurses unless they actually work. I think there is a feeling that when the operating room nurse is on call she has to stay at a certain place. We do not insist that the operating room nurses stay in the nurses' residence or in the hospital. They come in from their own homes.

DR. HURWITT: Mr. Andrews, are you willing to take sides?

MR. ANDREWS: I certainly am. If you have a person on call, whether she be at home or elsewhere, she is still at your convenience and the convenience of the hospital. I don't see how you can ask a person to stay at home and be on call without giving her some type of reimbursement. That's my own personal view.

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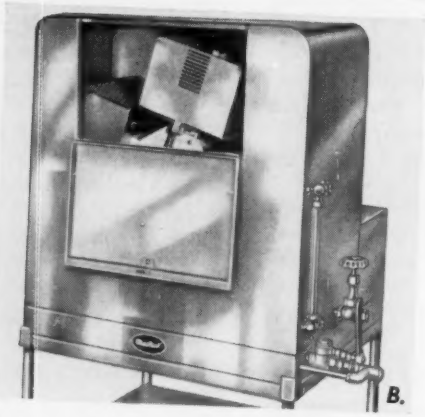
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What is Wrong with Conventional Central Service Planning

By Frederick E. Markus, Markus & Nocka, Boston, Mass.,
in collaboration with
Mrs. Jean Christie, R.N., Free Hospital for Women,
Brookline, Mass.

First in a Series

● No department in a hospital adapts itself so readily to the use of industrial production methods as does central service. Yet nowhere will there be found any production or service department in any industry which in its planning might serve as a pattern for the conventional central service planning in hospitals. By repetition, conventional central service planning has fallen into one general pattern, and the pattern is one which obviously requires the least thought on the part of the planner and yet produces the greatest frustration to a conscientious central service supervisor.

Consider for a moment the role of the planner of a typical central service department. Both the general plan and such details as appear necessary will in all probability be part of the assignment of a draftsman, who has not the slightest idea what actually takes place in central service. His usual approach is to copy or adapt a previous example to the available space. This practice accounts in large part for the obvious similarities found.

The draftsman can count on some help from manufacturers' representatives, and there may be a few suggestions from the hospital administration itself. The person who is finally responsible for the plan and its production facilities will rarely see the department in operation. He will never know whether it worked—well—badly—or not at all.

(Continued on next page)

Consider by contrast the planning of any department in industry. The planner must account for every last detail by collaborating with a group of specialists. The final product must represent the last word in production flow, methods timing, and tooling. It will be based on precise time and methods studies, flow analysis, and work place layouts. New concepts will be pretested with mockups and full-size working models. The job is not considered finished until it is operating smoothly and every last "bug" is ironed out. It will definitely not be a one-man job.

COMMON SHORTCOMINGS

A careful examination of some recently completed central service departments will illustrate the many shortcomings, which actually become monotonous by repetition. Here are a few of the most obvious shortcomings:

Case No. 1

Sterile supplies at opposite end of department from issuing window
Excess counter space
No general storage area for supplies
No knee space anywhere for seated operators
Poor sterilizer arrangement which produces constant arm burns during unloading*
Too much empty floor space
Office remote from everything
Dumb waiter remote from sterile storage.

Case No. 2

Allocated area inadequate
Two Dutch doors poorly located and neither used

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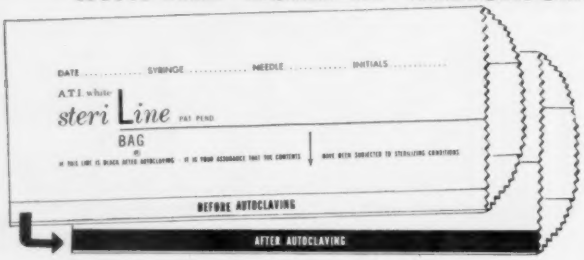

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No space for linen storage
No tables available nor space for linen folding
No knee space at any of the work counters
No space or service outlets for mechanized equipment
Glove powder machine standing in traffic lane
Partition subdivision with door which serves no purpose
No space for supervisor's desk or clerical work.

Case No. 3

Too much counter space
No space and service outlets for mechanized equipment
Mechanized equipment at random in passages unrelated to normal flow
Knee space not high enough to accommodate knees
One Dutch door poorly located and not used.

Case No. 4

Total area inadequate
Too much counter space
Receiving and cleaning very restricted
Single washing sinks, making rinsing awkward
Assembly work place areas too small
Mechanized equipment not anticipated
Dumb waiters poorly located
General storage space lacking
Truck passage space severely restricted
Truck parking space inadequate.

Case No. 5

Total area too large
Excess counter space
No foot rest at knee space
Too many individual rooms
Conveyor system poorly located

There is no point in continuing the list. The similarity of most of the shortcomings becomes quite obvious. They can be summarized somewhat as follows:

1. Dictation of plan by an arbitrarily selected area
2. Placing of a counter on every available wall
3. Lack of knee space or foot rests
4. Failure to include mechanized equipment in the original planning
5. Lack of empty floor space where required.

To this list should be added some less obvious items:

1. The fallacy of permanence at the price of flexibility
2. Lack of correctly designed work place layouts
3. Improper use of stainless steel.

EXPENSE NO CRITERION

The inadequacies of central service cannot necessarily be laid to limited budgets. The poorest plan observed contained the most expensive materials and the best equipment, a great expanse of terrazzo floor, wall tiled from floor to ceiling, no end of stainless steel counters (without a single knee hole), with almost everything in the wrong order, yet practically unchangeable, and, of course, so permanent that it could last a thousand years. Unfortunately, it was obsolete before it was finished.

The average central service supervisor, in taking over a new department, is almost immediately conscious of these shortcomings, yet can do very little about it. To complain when the pride of open house inspection is still glowing would be considered the height of disloyalty and ingratitude.

In almost every case a superior layout would have actually cost less, to say nothing of the saving in labor over the years, resulting from increased efficiency.

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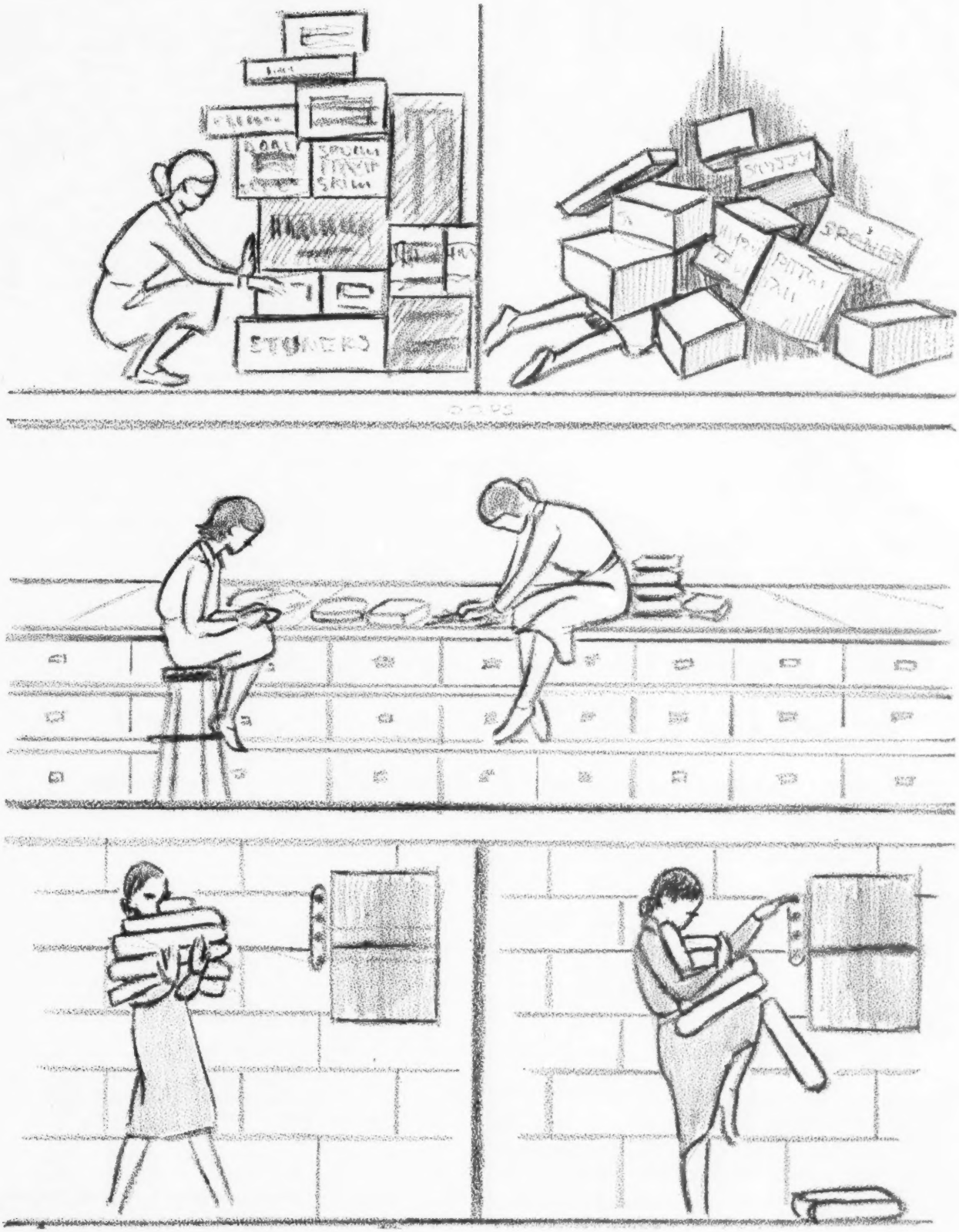

As a first step toward improvement, permanence should be discarded and the industrial theory of expendability substituted. Work stations should be for specific work type items and should be made as inexpensive and changeable as possible. In other words, a central service department should anticipate change in its original concept.

Planning a central service department requires precise knowledge of the different types and quantity of work to be performed. If the planner lacks this knowledge (which can be taken for granted), then he must certainly collaborate with those who do know. Nevertheless, to plan to advantage the planner must have a general knowledge of production methods, timing, and flow, but still count on the help of the specialists, including "the man at the bench."

With the exception of the few departments which are large beyond all reason, most central service departments lack empty floor space at the right places. There must be free floor space at the points at which trucks, hampers, etc., are loaded, unloaded, or just parked. If loading and unloading block traffic, as they now frequently do, then they interfere seriously with proper functioning.

A most unpardonable sin is the bad posture to which central service workers are subjected. Many states have laws concerning the posture of industrial employees, with special reference to seating. As the laws are written, however, hospitals, since they are not mentioned, are outside the laws' jurisdiction. Whether this omission was intentional or not is a question. It may be that it did not occur to the lawmakers to think in terms of workers in hospitals. Or did they assume that a hospital, of all places, would not condone bad posture for its own employees? The fact of the matter is that not a single instance has been observed in which seating arrangements meet even the minimum requirements of any of these laws. For example, a single hoop on a high stool is not acceptable as a foot rest. There must be a more natural, properly located rest for the feet.

Aside from the question of comfort, it has been frequently observed that work is done on the lap in preference to the table. The reason is that the worker, once seated, has difficulty in repositioning a high stool, without the firm foothold which is required to bring it closer to the table edge.

LACK OF KNEE SPACE

To provide knee holes which lack height clearance for the knees (because of deep drawers under the counter top) is inexcusable. Every normal designer has a pair of knees he can measure without getting up from his chair and so establish the required clearance.

For this lack of knee space, employees have been observed working while leaning against the counter (that is, with their backs toward the counter) and also actually sitting on the counter for certain work. Employees who do work which requires close inspection are forced to use a shelf under their counter as a hassock on which to place their feet, in order to be close enough to their work. Legs propped at an awkward angle can be looked upon as tragic or comical, depending on one's point of view.

The use of stainless steel throughout central service is open to considerable criticism. It causes a major cleaning problem because it finger-marks and spots so easily, and leaves stubborn black streaks on white shoes. Also, annoying glare may be caused by light reflection from this shining surface. Some workers use sheets of some pliable material to cover their work area, to prevent this glare and the extra cleaning—hurriedly removing these covers, of course, when inspection is about to occur. More thought should be given to the choice of surface materials used in specific locations.

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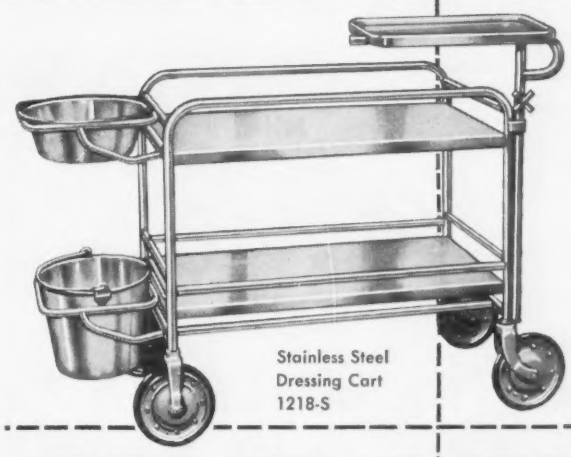

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Research Grants for Cystic Fibrosis Go to Columbia-Presbyterian

The first of a proposed series of grants for research in cystic fibrosis, was made by the Cystic Fibrosis Association to the Presbyterian Hospital at Columbia-Presbyterian Medical Center, New York City.

The first $5,200 grant from Karen and Kathie Saunders, who have cystic fibrosis, to Rustin McIntosh, M.D., director of pediatric service, was made recently.

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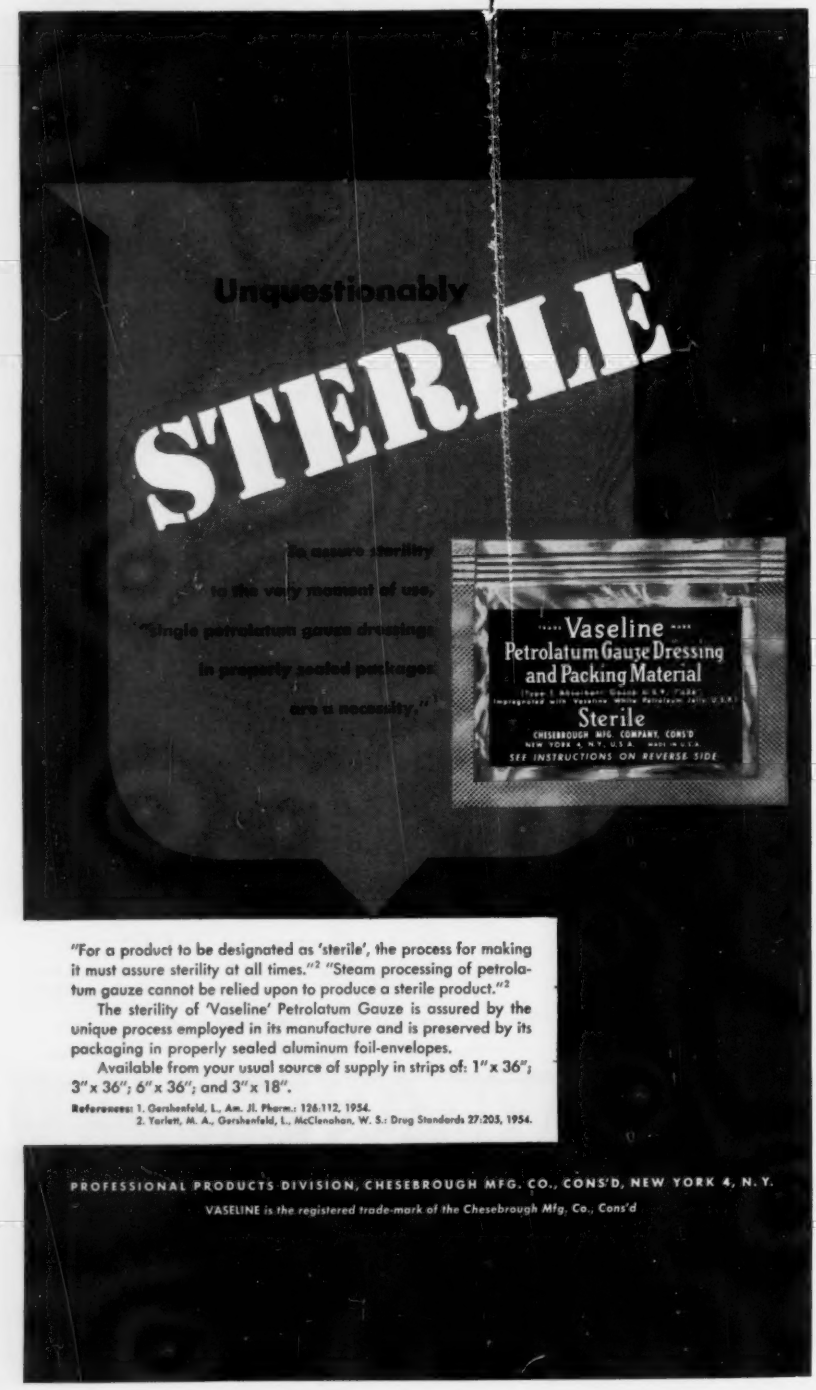

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References: 1. Gershenfeld, L., Am. Jl. Pharm.: 126:112, 1954.
2. Yarlett, M. A., Gershenfeld, L., McClenahan, W. S.: Drug Standards 27:203, 1954.

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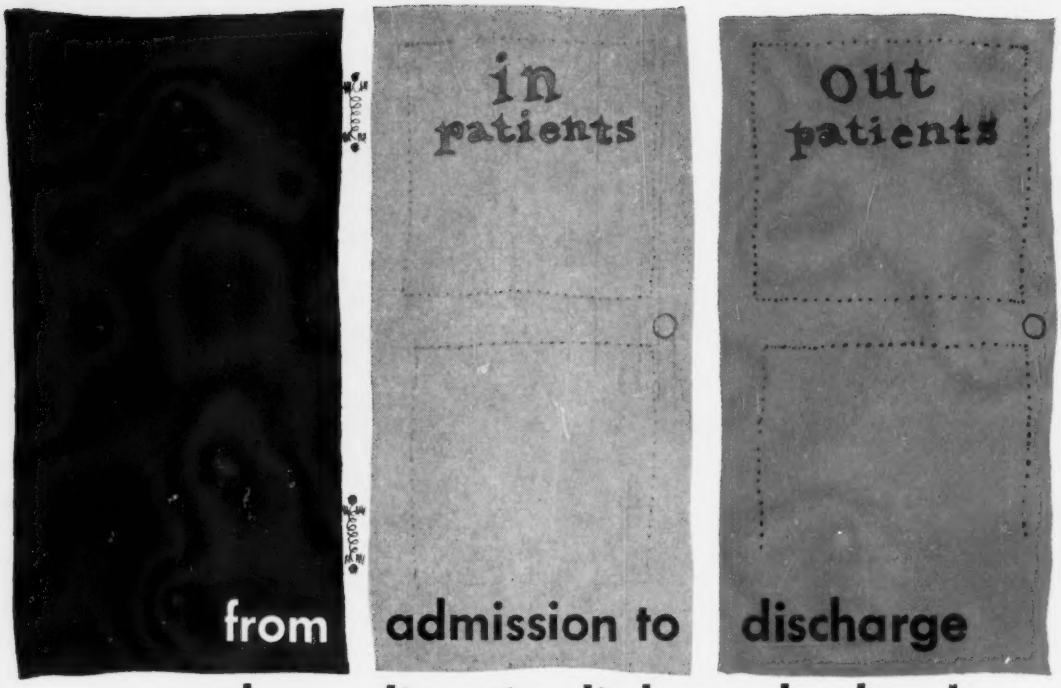

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